Maternal and Child Health Services
Title V Block Grant

State Narrative for Oregon

Application for 2010
Annual Report for 2008

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurance and certifications are on file in the Office of Family Health.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Office of Family Health (OFH) and Oregon Center for Children and Youth with Special Health Needs involves communities, stakeholders, and program participants, including family consultants, in policy and program decision-making at many levels. The priorities, budgeting and expenditures, performance measures trends and outcomes, are presented and reviewed by stakeholder and program participants of MCH and family health services across Oregon. The Title V and related programs outreach to local public health, tribal health, community-based organizations, primary care, and safety-net providers. The venues range from needs assessment processes and program evaluation to advisory committees and task force efforts.

/2008/ The Title V program created a website was created to encourage comments, suggestions and ongoing input into the priorities to improve health for the MCH population. (http://www.oregon.gov/DHS/ph/ofhs/mch/mch.shtml#mch)
Other opportunities for public input occurred through public meetings and sessions with stakeholders and local partners, such as Conference of Local Health Officials- MCH Committee and local Nursing Supervisors. Input into the priorities OCCYSHN family consultants provide input on program and policy development in both OCCYSHN and in OFH, and links other family consultants to participate in planning activities beyond Title V program areas. //2008//
/2009/ The OFH reviewed the Title V budget with MCH-CLHO in Fall 2007 to solicit input on the linking of the budget with goals and performance measures.
Shared priority setting and strategic planning to improve perinatal health status engaged the public health nurses and the Title V program. //2009//

/2009/ In June, 2008, OCCYSHN provided an educational and feedback session with 8 families of children/youth with special needs, from rural communities and small urban communities, and Family Liaisons in the Community Connections Network. The session provided overview of OCCYSHN and asked families about their priorities in their communities for CYHSN, how well programs were addressing those needs, and suggestions and recommendations for improvement. Families

identified health care access and need for mental health services as primary concerns and priorities throughout the state. They also emphasized the needs of non-
English speaking families and families who are non-readers or have lower literacy levels. Both of OCCYSHN's community based programs, CaCoon and Community
Connections are considered very helpful to families. However, this group indicated that additional marketing was needed to assure that families and providers are
aware of the programs and know how to access them.
//2009//

/2009/ In addition to the emphasis on sharing the block grant with families, OCCYSHN also interacted with its partners through the local public health departments
and local community teams through the end of year reflection and evaluation meetings to secure input regarding unmet and emerging needs of CYSHN.
Repeatedly issues related to behavioral and mental health and oral health are cited as areas of growing unmet need. OCCYSHN relies on this local input to help
shape its priorities for the coming program year. //2009//

/2010/ Oregon Title V Office (Office of Family Health) has updated its web resources and capacity for public comment on the Block Grant, particularly its five-year priorities. This website is fairly new and is planned for extensive use during the upcoming needs assessment. Additionally, the web platform used by the Dept of Human Services is scheduled to be improved over the next year, allowing for improved interactivity and functionality. The website and public comment can be found at http://www.oregon.gov/DHS/ph/ch/mch.shtml .

During 2008-09, the Title V Office invited stakeholders and the public to participate in a symposium for maternal depression, allowing for public input into prioritizing issues and strategies. With the 2010 Needs Assessment and improved capacity for assessment and evaluation, the Oregon Title V Office will be incorporating public input through broad-based advisory groups, community-based focused groups, and continued shared planning around priorities.

OCCYSHN plans to link with OFH website and will make the block grant available on its website to with a link for comments and questions, as well as an indication of interest in participating in block grant planning and evaluation. By early fall 2009 OCCYSHN will distribute a newsletter describing the key elements of the block grant and FY10 activities with a link and an invitation for input. The newsletter has a distribution list of over 1000 recipients throughout Oregon.

In June 2009 OCCYSHN asked for input on program activities addressing transition from its Youth Advisory Group (YAG). YAG members provided feedback about unmet needs related to transition to adulthood. Two key informant interviews were conducted. OCCYSHN is formulating a plan for further input during July 2009 from families and its county and community level partners around the state through conversations and a group and individual basis.

//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Oregon Title V Needs Assessment priorities are focused on capacity building and leadership to better address current and emerging issues for the MCH population. Summarized below are the ongoing assessment activities in 2008-09.

Population assessment:

- In 2007, the Title V Program completed a comprehensive, in-depth look at the health status of pregnant women and birth outcomes in Oregon to explore priorities and needs. This information was published as the Oregon Perinatal Data Book. The Data Book is comprised of leading perinatal health indicators that describe the overall picture of perinatal health in Oregon, with data obtained from Vital Statistics, PRAMS, and the National Immunization Survey. The Data Book was instrumental in a priority setting function shared between local public health nurse supervisors and the Title V Program in OFH. The result was two priorities for which action plans have been developed -- preconception/inter-conception care and perinatal depression.

- In Summer 2008, an intern is conducting an in-depth look at the Oregon results of the National Survey of Children's Health. The outcome of this study will help to provide direction about priorities in child health status that will help shape program priorities and provide some basis for the next Title V needs assessment.

- The Adolescent Health Program is working in ongoing needs assessment and priority setting by incorporating Youth Action Research methods to identify needs, priorities and goals based on the input of youth. The information from this research will be used to the development of strategies and policy recommendations for the new teen pregnancy prevention/adolescent sexual health State Plan.

- A School Based Health Center Mental Health Needs Assessment online survey was completed by each of the SBHCs to assess in detail their mental health staffing and capacity in order to understand where gaps exist. This information will be used to provide technical assistance and training to SBHCs in having better organization of existing mental health services, as well as serving as a capacity baseline when planning for future mental health services.

- OCCYSHN designed a question for the Oregon Healthy Teens Survey to better understand behaviors of adolescents with special health needs

- OCCYSHN evaluated qualitative data and information to assess the need to improve program services on behavioral health, family involvement, access and adolescent transition

Evaluation capacity improvement:

- OFH has instituted its planned Evaluation and Epidemiology Unit within the newly restructured MCH Section in the Office of Family Health. Development of this unit was one of the highest priorities identified in the MCH Capacity Assessment conducted as part of the needs assessment.

- ORCHIDS -- the MCH client data system in development for many years -- finally rolled out in 2008 and will provide much needed information to evaluate local MCH program delivery.

- OFH is conducting a small study to ascertain whether Medicaid citizenship verification laws, implemented in 2006, were associated with any delay in Medicaid eligibility determination for

pregnant women in Oregon. If the data indicate that a delay occurred, we will examine the effect of this delay on timeliness and quality of prenatal care.

Leadership capacity building;
- OCCYSHN is collaborating with private groups and public agencies to explore the health access concerns for CYSHN as related to insurance coverage, training for providers and assessing capacity of nursing groups (school nursing, home health nurse and public health nurses) to address care coordination needs.

- Office of Family Health annually conducts a series of informational sessions for public health staff to share their work and outcomes, assisting in the professional development of staff. This series has taken on a different framework each year and in 2008, the theme is "Lessons Learned in Program Evaluation and Design."

- OFH and OCCYSHN staff and managers are attending both Public Health Leadership and MCH Leadership programs. During 2007-08, two of the new MCH managers MCH attended the National MCH Leadership Academy, two staff completed a DHS Leadership Academy, and others attended the national Program Evaluation Association meeting held in Portland in late 2007.

III. State Overview

A. Overview

Oregon's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Oregon's maternal and child health population. The Title V Program functions across agencies in the Office of Family Health (OFH) in the Department of Human Services, Public Health Division, and in the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) from within the Child Development and Rehabilitation Center at the Oregon Health and Sciences University. The Title V Administrators from both agencies assure a comprehensive, cross-agency approach to understand and plan activities supporting Oregon's MCH population issues and needs. Activities include jointly reviewing epidemiological data and information from stakeholder and public input activities, assuring state and local staff are adequately trained in MCH program and policy development, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V Program at both the operational and population-health levels. The Title V programs utilize multiple frameworks to develop and promote strategies and recommendations to stakeholders and policy makers, key among which are the Core Functions of Public Health, , Essential Public Health Services, and the MCH Health Services Pyramid to.

OCCYSHN utilizes an array of methods to ascertain and establish priorities for its activities. These include secondary analysis of national survey data, primary data collection through community-based needs assessment, and ongoing input from families, community providers, and state partners. Alignment with OHSU and its teaching and research centers benefits OCCYSHN's commitment to provide high quality leadership on behalf of Oregon's children and youth with special health needs. This relationship also creates unique opportunities to provide education to families Oregon's health care providers.

1. Oregon Environment

Oregon is located in the Pacific Northwest with a population of 3.5 million living in 96,545 square miles. Oregon is primarily a rural state, with a population density of 37 people per square mile. Portland is the major urban center, with approximately 1.5 million people in a tri-county area. There are 43 member tribes of the Northwest Portland Area Indian Health Board and other urban health facilities located in Oregon, Washington and Idaho. Other urban areas include Salem, the state capital, Eugene, in the mid-Willamette Valley, and Medford, in Southern Oregon. Oregon has many state parks and national forests with an abundance of outdoor recreational opportunities, from windsurfing to backpacking and fishing to walking or biking on Portland's 40 mile-loop.

/2008/ Oregon's population continues to increase overall according to the 2006 Population Survey (http://www.oregon.gov/DAS/OEA/popsurvey.shtml). The rate of people migrating to Oregon in the past five years grew from 17 percent in 2004 to 23 percent in 2006. An increase occurred in all regions but Region 4 (five counties in southwest Oregon), which remained the same as in 2004. Region 1, generally rural (three north coast counties plus Columbia County), saw a 10-percentage point increase; Region 2, primarily urban (Clackamas, Multnomah, Washington and Yamhill counties), experienced a 9-percentage point increase. In rural central Oregon, Deschutes County reported a 29% increase in their population and neighboring Crook County reported a 20% growth in population. A shift in the ethnic diversity is also occurring, best demonstrated in Washington County where in the town of Hillsboro the population has more than doubled since 1990 with the Latino population increasing more than fourfold (from 11% in 1990 to 21% in 2005% //2008//

/2009/ Oregon's population grew by 1.5% between July 2006 and July 2007, to reach 3,745,455, a slower growth than the 1.6% of 2005-2006. This is the first year of decline since 2002, when growth was under 1.% at the time of recession. However, Oregon is ranked 11th fastest in the

nation in 2007. (Oregon Employment Dept. Article, April, 2008; http://olmis.emp.state.or.us/olmisj/ArticleReader?itemid=00005899). //2009//

/2010/ Oregon's estimated population on July 1, 2008 reached 3,791,075, increasing by 1.2 percent over 2007 population. Oregon's population growth is expected to slow down in the near future, with the current forecast to be around 1.14 percent per year between 2008 and 2015. Total Hispanic population will continue to grow at a slightly faster rate than other races and ethnicities in Oregon. (State Population Projections, U.S. Census Bureau,2005). While the growth of the cohort of ages 65-74 will increase in the near future, it is expected that the cohort that reaching ages 45-64 will be close to zero by 2012. The young adult population aged 18-24, will slowly grow as well. The population of children under the age of five shows a higher growth rate than the non-elderly population, but remains below the overall population growth. The age group 24-44 is seeing positive growth over the last couple of years and will approach 1.2 percent annual growth by 2011. Oregon's fertility rate is expected to be 2.0 per woman through 2015. (Oregon Economic and Revenue Forecast, Vol. XXIX, No. 2, May 2009, Oregon Office of Economic Analysis. //2010//

/2009/ The 2006 American Community Survey ranks states with respect to median household income and percentage of people in poverty. Median household income for Oregon overall is $46,230, a significant increase of 4.3%, ranking 27th in the U.S., between 2005 and 2006; the U.S. overall was $48,451, a 1.6% increase. Oregon's income-to-poverty ratio less than 100% FPL is 13.3% or 480,613 persons, ranking 32nd in the U.S. in the in the 2006 ACS survey, where the Oregon ranks 30th overall compared to other states. (U.S. Census Bureau, 2006 American Community Survey). //2009//

/2009/ The 2008 Oregon Benchmark Race and Ethnicity Report (Oregon Progress Board, May 2008) remarks that, while Oregon continues to become a more diverse state, it is less racially and ethnically diverse than the U.S. as a whole. From 2006 Census population projections, 86.1% Oregonians classify themselves as White, compared to 73.9% in the U.S. African Americans are the least represented group in Oregon, at 1.7% compared to 12.4% in the U.S. overall. Asian/Pacific Islanders have increased slightly to 3.9% of the population while the U.S. API population is at 4.4%. American Indians are more represented in Oregon than the U.S., at 1.8% and 0.8% respectively. Oregon experienced an increase in the Hispanic population between 2000 and 2006, from 4% to 10.2% in that time period, though this is lower than the 14.8% increase across the U.S. during the same time period.//2009//

/2010/ The 2007 National Survey of Children's Health (http://nschdata.org/StateProfiles) shows stabilization and improvement in many of the reported key indicators. Small improvements in the indicators for children receiving a preventive health visit in the last year (70.6 percent in 2003 and 79.7 percent in 2007) and children ever breastfed (87 percent in 2003 and 89.2 percent in 2007). (Oregon leads the US in breastfeeding rates). Indicators that show decline include the percent of children 0-5 with injuries needing medical attention, from 11 percent in 2003 to 9.4 percent in 2007 and the percent of children age 2-17 with problems requiring counseling who received mental health care, 62.7 percent in 2003 to 46.2 percent in 2007. Compared to the U.S., the NSCH shows that Oregon ranks higher in the percent of children in excellent or good health status, though lower than the U.S. in percent of children with health insurance or receiving a preventive health visit in the past year. Oregon's children show lower than the U.S. in the percentage of children aged 4 months to 5 years to be at moderate to high risk for developmental delays based on parent concern, 19.4 percent compared to the U.S. rate of 26.4 percent. Additionally, the only 13.5 percent of children aged 10 months to 5 years received a standardized screening for developmental or behavioral problems, compared to 19.5 percent in the U.S. Indicators for school and activities, the child's family, and the child and family's neighborhood all rank higher than the U.S. for Oregon's families. More research with the NSCH will be taking place over the next year and in conjunction with the

2010 Needs Assessment. //2010//

2. Economic Environment

The median income for Oregon for a family of 4 is $36,157 (2005). The total population making 100% or less of the federal poverty level (2002-2003) is 16%, with a total of 35% of the population considered low income (Kaiser Foundation, State Health Facts: www.statehealthfacts.kff.org). The unemployment rate (May 2005) remains at 6.5 percent, less than 2004, but still higher the U.S. 5.1 percent. The fastest growing industries are business administrative and business support services and health service industries: ambulatory health care, hospitals, and nursing and residential care. Health services are likely to continue to grow along with the population due, in part, to the increasing demands of the aging baby boom population.

/2007/ Unemployment rates reached a peak of 8.5 in Summer 2003, but has steadily improved since then. The rate fell to 5.5 in April 2006, though this is still higher the national rate for that month which was 4.7. /2008/ Oregon's unemployment rate was 4.7 in May 2007 (5.0 seasonally adjusted), much improved but slightly higher than the national rate of 4.3 (4.5 seasonally adjusted). (http://www.employment.oregon.gov/employ/budget/ui/index.shtml) //2008//

/2009/ The unemployment rate for May 2008, was 5.6% up slightly from April 2008 at 5.4%. the U.S. rate was 5.5% in May an 5.0% in April, 2008. Although Oregon's rate has been higher than the U.S. rate for many years, the gap has been narrowing and now the difference between the two is not statistically significant. (Oregon Employment Department, May, 2008 http://www.oregon.gov/EMPLOY/COMM/news/may_2008_unemployment.shtml) //2009//

/2010/ Oregon has been significantly hard hit by the current economic recession. Oregon's seasonally adjusted unemployment rate in May 2009 was 12.4 percent, rising from 11.8 percent in April. This rate is higher than 12.1 percent set in November 1982, and twice as high as the 5.7 percent rate in May 2008. This compares with the U.S. rate of 9.4 percent in May, which increased from 8.9 percent in April. In May, 240,615 Oregonians were unemployed. In May 2008, 103,441 Oregonians were unemployed. While the May unemployment rate is at a historically high level, the increase in Oregon's unemployment rate has moderated at 0.5 percentage point over a two month period. This moderation in the rise of the unemployment rate followed a trend of very rapid monthly increases between October 2008 (when the rate was 7.2 percent) and March 2009. (Oregon Employment Dept., News Release, June 15, 2009) //2010//

/2010/ The effect of unemployment on revenue forecasts in Oregon is significant. Oregon does not have a sales tax, which is a benefit for consumers, but the leading source for tax revenue comes from income taxes and therefore highly vulnerable to fluctuations in employment rates. With the unemployment rate more than doubling in the second year of the biennial budget, the reductions in state general fund budgets were significant in 2008-09. The revenue forecast for the second year of the biennium was down by $260.0 million from the March 2008 forecast, resulting in a negative ending balance of $351.3 million. The unanticipated shortfall late in the state's biennium required short-term solutions. The Governor required furloughs for state management and unrepresented employees in March-June of 2009, and has extended the furloughs through August. Labor negotiations for the next biennium are not yet complete, but it is expected that furloughs will be part of the final agreement, with a complete closing of state government (except for essential services) throughout the biennium. The net savings for furloughs the Public Health Division (PHD) is $63,194 in General Fund, in the amount of $59,205 Other funds, and $218,479 in Federal Funds, totaling $340,878 for the PHD overall. Budgets for 2009-2011 include across-the- board 4 percent reduction in personal services and 2 percent reduction in services/supplies.

County governments are having similar budget cutting issues and are cutting their open

hours, including employee furloughs. State public health budgets for funding provided to counties includes elimination of the 2.8% cost of living increases for all fund types. Budget proposal to increase the Public Health Per Capita rates was not approved in this legislation session. //2010//

/2007/ The annual report card published by Children First of Oregon in September 2005, reports that the rate of child poverty increased from 17.5% to 19.1% or approximately 160,000 children. The poverty rates for the total population show disparities for specific populations: White: 24% in Oregon compared to 33% nationally; Black 24% in Oregon compared to 33% nationally; Hispanic is 34% in Oregon compared to 29% nationally; and "other" is 21% in Oregon and 19% nationally (2003-04; Kaiser Family Foundation, www. Statehealthfacts.org) //2007//

/2008/ The Oregon Population Survey for 2006 found Oregon's median household income increased from $40,569 to $42,021 between 2003 and 2005. Adjusted for 1989 dollars, income decreased from $26,220 to $25,813 during that period.
(http://www.oregon.gov/DAS/OEA/popsurvey.shtml) //2008//

/2008/ At the federal level, a multi-year reauthorization of the Secure Rural Schools and Community Self Determination Act, which technically expired in September 2006 and extended for one year, is threatening the infrastructure of Oregon's counties who relied on the timber industry to support local services. The Rural Schools Act provided $1.6 billion to 33 of 36 Oregon counties in payments to compensate for lower revenues from reduced timber harvests on federal land. Without these funds, 23 counties face losses of more than 20% to their county general or road funds. In three counties, the revenue amounted to 60% of their county general funds, and in other counties 70% of their county road funds. With the expiration of these payments, counties have already begun to cut services, such as law enforcement, public safety and public health services. Counties that relied heavily on General Fund timber revenue have low permanent property tax rates, as set by a state property tax limitation, Measure 50, rates. (Presentation on Federal Forest Payments and County Services, by Association of Oregon Counties, January 23, 2008; http://www.aocweb.org/aoc/Portals/0/Content_Managers/FFP%20Generic%20Package.pdf). Some counties will try for tax levies to begin shifting costs locally; however, even if levies are passed, the collection and transition from one revenue source to another will be result in a reduction of services and will not be at the same level as the timber tax revenues. Oregon state and local public health officials are making strategic plans to assure public health services continue in the county, even if by a contractor other than the county health department. //2008//

/2009/ In 2007, Gov. Kulongoski appointed a task force to review Oregon's tax revenue system to determine ways to provide support for local services in the counties that are hardest hit. The Task Force report will be released sometime in summer, 2008, and is expected to provide recommendations for flexibility for counties to levy property taxes, currently limited in Measure 50, or allow use of lodging taxes for basic services. //2009//

/2010/ Included in the American Recovery and Reinvestment Act was a provision to reinstate federal timber payments for four years. This is great news for Oregon counties who are facing significant shortfalls in both state and local revenue sources. This is a short term reinstatement gives a window for Oregon to find local solutions to replace the $282 million in federal revenue that will be phased out. HB 2920 was passed by the 2009 Legislature to create a Task Force on Effective and Cost-Efficient Service Provision. The Task Force will lead planning to build sustainable tax structure in preparation for the federal payment phase out. //2010//

3. Health Insurance Access

Health care services are accessed through private providers and hospitals, paid through private hospitals and managed care plans, including the Oregon Health Plan, a Medicaid waiver program, a safety net system that is linked through community health care and partnerships with private health care providers. Systems to link private and public health care services exist

through medical associations, the medical and dental directors of the Oregon Health Plan, the Office of Rural Health, and medical, nursing and dental academic and training programs.

There are approximately 229,000 children enrolled in the Oregon Health Plan, but it is estimated that another 66,000 remain uninsured. When OHP reduces enrollment or benefits, parents may find it difficult to discern that their children may still qualify for benefits. It is difficult in many areas to find providers who will accept the patients covered by OHP due to perceived low reimbursement rates. Language and cultural differences can be barriers to enrolling in publicly funded insurance programs. African-American, Native American and Hispanic children are less likely to be insured than white, non-Hispanic children both locally and nationally. (Office for Oregon Health Policy and Research http://egov.oregon.gov/ das/ohppr/ rsch/doc_rep_present.shtml).

/2007/ In March, 2006, the Office for Oregon Health Policy and Research released a report, "Profile of Oregon's Uninsured--2004." (http://www.oregon.gov/das/ohpr). In 2004, the national uninsured rate was 15.7%, and during the same time, 17% of Oregonians are without health insurance coverage, an increase from 14% in 2002. This represents more than 609,000 individuals of all ages, 117,725 who are children under the age of 19. Over half (53%) of the currently uninsured children may qualify for SCHIP, which offers coverage for incomes up to 185% of the federal poverty level, or $34,873 for a family of four in 2004. A statewide survey of parents, conducted in 2005 through the Office for Oregon Health Policy and Research found that the required period of uninsurance, the 6-month enrollment periods and a fairly complicated application all contributed to breaks in coverage for low-income children. The Profile reports that: young working-age adults (18 to 24) are very likely to be without coverage. Approximately 62% of the uninsured 18 to 24 year olds had household incomes of less than 200% of the federal poverty level, and 64% are working. The disparities among Oregon's largest minority population, Spanish, Hispanic or Latino, are twice as likely to be uninsured (34.2%) as the general population. The Profile reports that over 15% of those who are uninsured reported that they have a lasting physical (24%), mental (24%), developmental or learning (11%). (from the Oregon Population Survey, 2004, reported in the Profile of the Uninsured, Office for Oregon Health Policy and Research http://www.oregon.gov/das/ohpr). //2007//

/2009/ The 2006 survey of the Oregon Health Policy study of insurance shows 12.6% of children under the age of 19 (116,000) lacked health insurance coverage last year, compared to 13% in 2004. //2009//

/2010/ Data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) estimate that 11.2 percent of Oregon CSHCN ages 0 to 17 were without health insurance at some point in the prior year. This same figure was estimated to be 15.4 percent using data from the 2001 NS-CSHCN. //2010//

/2007/ Oregon Senate Bill 1, the Mental Health Parity Bill, will take effect January 2007. This legislation requires insurance companies to offer as much coverage for mental illnesses as for physical ailments. Concern exists that as the rules are written that limits on the coverage for treatments will limit the access to those CYSHN that require treatments for optimal growth and development. OCCYSHN will partner with advocacy and providers group to advance the parity of services in all areas for children and youth with special health needs //2007//

/2008/ Legislative summary for health insurance access:
SB 3, Healthy Kids Plan: This legislation was introduced by the Governor under several bills, all of which created a Healthy Kids Fund to provide resources for increased coverage by Medicaid to family income of 250% of Federal Poverty Level to pregnant women and children up to age 24. The Private Health Partnership is created to provide support for families up to 250% FPL and ineligible for the Oregon Health Plan, to purchase health insurance. With bipartisan support for the Healthy Kids Plan, the funding mechanism to raise taxes on tobacco sales to 84.5 cents per pack stalled the bill. The final legislation referred the Healthy Kids Plan to the voters in Fall,

2007, as a constitutional amendment that will dedicate tobacco tax revenues to provide health care to children, low-income adults and other medically underserved Oregonians and to tobacco use prevention and education. /2009/ This amendment did not pass in Fall 2007. //2009//
House Bill 2406 directs the DHS to apply for a Medicaid Waiver for medically-involved children to allow families to move their children out of institutions and back home with the more comprehensive services that Medicaid provides. Approximately $3 million was allocated through the DHS Seniors and Disability Division to fund this bill.
HB 2918, the insurance parity bill for children with pervasive developmental disabilities passed, as well. This measure requires a health benefit plan to cover treatment of a child under 18 who has been diagnosed with pervasive developmental disorder subject to the same conditions as treatment of physical illness. For purposes of the legislation, a pervasive developmental disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.
Approved budget increases in DHS for payment of services included a $3.8 million biennial increase for the Family Planning Expansion Project to continue covering reproductive health services for all women in Oregon.
SB 329 Creates Healthy Oregon Act, establishes Oregon Health Fund program, and establishes Oregon Health Board to administer program; key directives include developing a comprehensive plan and proposal for financing Oregon Health Fund program and identifying health services to be provided by program, that support principles of equity, public priorities, effectiveness, efficiency, collaborative, coordinated, family-centered, and financially sustainable. Recommendations and a plan are to be reported to the 2009 Legislature. //2008//

/2009/ Oregon Health Fund Board and task forces have been meeting over the last year to develop a comprehensive plan to ensure access to health care for all Oregonians. The Board is expected to provide recommendations that contain health care costs and address issues of health care quality. Governor Kulongoski has reiterated his commitment to ensuring affordable health care coverage for children and low income adults in a letter to the Health Fund Board in June, 2008 (http://www.oregon.gov/OHPPR/HFB/index.shtml). In his letter, he requests the Board to consider revenue options, including tobacco taxes, to support these priorities. The Governor's 2009 Budget Request will include funding requests for health care access improvements based on the Health Fund Board's recommendations. //2009//

/2010/ The 2009 Oregon Legislative Session will be historically recognized as a milestone in changing the course of health care for Oregonians. Several of the Oregon Health Fund Board proposals were passed and will change the landscape of health in near future. While high unemployment rates are impacting the health of every Oregonian, the innovations for improving health may offset some of those impacts in the long term. The Oregon Health Fund proposals that are most significant are the creation of the Oregon Health Authority (HB 2009) and the Healthy Kids Plan (HB 2116).

1) The Oregon Health Authority will streamline state health functions including state health agencies and purchasers of public health care into one agency to improve efficiencies in the state's patchwork of health policy and health issues. It creates a Health Policy Board, citizen-led and Governor appointed members. The Health Authority is mandated to begin the first steps for implementing recommendations of the Oregon Health Fund Board (which is dissolved), including a public employer purchasing collaborative, clinical improvement assessment project, patient-centered primary care homes and payment reform, coordination of electronic health record adoption and interconnectivity, health care workforce initiative, and improve transparency for healthcare facilities, insurers, and claims reporting. The Public Health Division and Title V programs (though not OHSU children with special health needs programs) will be part of this new authority. Planning for implementation will occur over the next two years, with transitions recommendations going forth to the 2011 Legislative Session. The values and goals of the Oregon Health Authority align well with those of Title V and changes are not expected as part of this new Authority.

2) The Healthy Kids Plan will insure all children up to age 18 reducing the uninsurance rate from 12 percent to 5 percent in 18-24 months. The law taxes hospitals and health plans to fund expansion of insurance, expands school based health centers, and, in return, increases reimbursement rates. The coverage is as follows: children in families up to 200 percent of the federal poverty level will be eligible for the Oregon Health Plan or employer sponsored health insurance, subsidizing the full cost of premiums and co-payment. Children of families between 200 and 300 percent of the federal poverty level will be eligible assistance for premiums for the Oregon Health Plan or employer-sponsored insurance and will be responsible for co-payments. And children of families over 300 percent of the federal poverty level pay full premiums and co-payments for employer-sponsored insurance (existing system). Roll out of the Healthy Kids Plan is on fast track, with the goal of reaching out to 60,000 children currently eligible and in October, expanding outreach to another 100,000. The Oregon Title V Program is partnering with the Division of Medical Assistance Programs to develop outreach strategies and in addressing provider access issues. The bill also allocates funding for a Safety Net Capacity Grant Program, to assure children will have access to primary care, mental/behavioral, and oral health services and that statewide safety net providers have adequate capacity to meet the needs of the newly enrolled children. The bill also expands School-Based Health Centers to 55 centers, increasing access up to 7,000 students. //2010//

4. Health Care and Safety Net Access

Populations facing barriers to primary or preventive health services include people living in frontier and rural areas, Hispanics, migrant farm workers, and resident uninsured adults ineligible for the Oregon Health Plan.

Oregon's health care safety net is comprised of a broad range of local non-profit organizations, government agencies, school-based health centers, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care services they need. Health care safety net clinics in Oregon are staffed by physicians, nurse practitioners, physician assistants, nurses, dentists, social workers, community health workers, other health care providers, and volunteers.

Oregon's health care safety net clinics include:
32 Federally Qualified Health Centers (some at county health departments)
30 Rural Health Clinics
10 Indian/Tribal Health Clinics
40 School-Based Health Centers
35 County Health Departments
15 Community Clinics
7 Migrant Health Centers

These clinics vary in terms of size, number/types of professionals employed, client characteristics, service area population density and demographics, diversity and stability of revenue sources, as well as sophistication in practice and business management practices. Primary care services provided by the safety net include, but are not limited to: urgent care, acute and chronic disease treatment, services based on local community need (mental health, dental, and vision), preventive care, well childcare, and enabling services (translation/interpretation, case management, transportation and outreach).

Migrant and seasonal farmworkers support a multi-billion dollar agricultural industry. According to the Oregon Migrant and Seasonal Farmworker Enumeration Profiles Study completed by Alice Larson, Ph.D., September, 2002: The Migrant and Seasonal Farmworker population is estimated at 174,484, including 14,558 Migrant Children and Youth, 44,905 Seasonal Children and youth. Commonly reported health problems among Migrant Farmworkers and their children include: lower height and weight, respiratory disease, parasitic conditions, skin infections, chronic

diarrhea, vitamin A deficiency, accidental injury, heat-related illness and chemical poisoning. Non-resident pregnant women are not eligible for Oregon Health Plan covered prenatal care and must rely on federal (Title V) and state funds and public clinics for that care.

/2010/ Geographic Access to Care for MCH and CSCHN populations: Of Oregon's 36 counties, 23 of have at least one practicing pediatrician. One of these pediatricians, however, is not accepting new Medicaid patients. Of the 13 counties without a practicing pediatrician, 11 are located in rural or frontier counties in central and eastern regions of the state; the remaining two are located in the northernmost and southernmost areas of the Oregon coast. A network of Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs) and school-based health centers (SBHCs) is located throughout the state. Similarly to the distribution of pediatricians, far fewer of these centers operate in the rural and frontier counties of central or eastern regions of the state. Children living in the easternmost reaches of the state are more likely to travel to Boise, Idaho, or to Walla Walla and Kennewick in Washington State than to Portland or other metropolitan areas in Oregon. These communities are significantly geographically closer than the metropolitan areas of Oregon, which are located in the western side of the state. A lack of Medicaid interstate transportability has made it increasingly difficult for children to receive care in Idaho or Washington.

Geography represents a significant barrier to obtaining care for CSHCN, and specialty care in particular. Specialty care services for children are concentrated in Oregon's largest metropolitan area, Portland, located in the northwestern area of the state. Portland is the location of the state's only teaching hospital, Oregon Health & Science University (OHSU). Some specialty care services are available in the other metropolitan areas of the state, Eugene, Medford, and Bend. Cardiology is the most commonly available specialty service available in these and other outlying communities. Little to no specialty care services are available in the rural and frontier counties of central or eastern Oregon. Similar to the rest of the nation, dental and mental health services are the most difficult services to access geographically. Capacity is also quite constrained in areas that are more populous. The concentration of services in this area, referred to as "the I-5 Corridor," poses a significant financial burden for many families. In addition to the cost of transportation, driving to Portland or another metropolitan area also requires taking time off from work and paying for overnight accommodations. //2010//

2007/ Targeted Case Management: A collaboration and agreement with the Title V Programs in OFH and OCCYSHN, the Dept. of Education and Developmental Disability Services established a priority billing system for Targeted Case Management (TCM). This agreement will allow improved ability to address the care coordination and service delivery needs, avoid duplication of services, optimize resources and ultimately improve access to care for families. //2007// /2008/ The focus has shifted to find and establish other financing for home visiting/high risk infant case management, as the limitations and proposed changes in TCM may reduce the capacity of the services. //2008//
/2009/ The billing priorities resulted in unanticipated risks for loss of services to at- risk children and were therefore discontinued. SPA revisions are being drafted that more accurately define public health nursing program target populations. OFH and OCCYSHN continue to pursue other funding strategies to decrease public health dependence on TCM resources. //2009//

/2007/ The Oregon School-Based Health Centers seek to improve adolescent health through prevention, primary care, and mental health services delivered in an accessible, developmentally appropriate framework that helps support the educational mission. In Oregon, there are 45 Centers in 17 Counties, 28 High Schools, 8 Elementary Schools, 1 K-12 School, 8 Middle Schools; 39,249 students had access to SBHCs at their school and Oregon SBHCs served 17,702 clients in 56,633 visits; 53% of SBHC's clients were uninsured and 71% of SBHC clients reported they were unlikely to receive care outside of the SBHC. //2007//

/2010/ HB 2116 provides a funding mechanism to expand School Based Health Centers to 55 clinics, reaching up to $7,000. The same bill will generate revenue that will provide $5 million per biennium for safety net clinics to improve work force and capacity and serve up to 7500 ineligible legal immigrant children. //2010//

/2009/ The Commonwealth Fund's 2008 State Scorecard in Child Health System Performance shows Oregon is lagging behind other states in several indicators. Oregon ranks 43 in overall child health system performance. This includes a ranking of 26th for access, 29th for quality, 24th in costs, and 47th in equity. Oregon ranked 24th in the potential for children to lead healthy lives. The Title V program is concerned about these rankings and will be taking steps to understand and assess the low ranking in equity (children without medical homes and children without both a medical and dental preventive care visit in the past year). //2009//

/2010/ The "integrated health home" model has progressed to Legislative priorities. The bill, HB 3418, requires Oregon's Medicaid agency to develop a payment system to fund the integrated health home model for providers. The intent is to find ways to fund the services that link and coordinate primary care, mental health care, and the care coordination that must occur between those services. A study and report is due to the 2011 Legislative session. The Oregon Title V Program will participate in these conversations, adding expertise and information about the medical home models that have existed for children with special health needs. //2010//

/2008/ In 2007, OFH developed a system to allocate Title V funds to any of the nine tribal governments in Oregon. To assist in start up and to equitably include the tribes in the existing funding formula for county health departments, OFH has set up a planning mini-grant fund to support development of the program, data and a triennial plan. To date, two tribes have applied for these mini-grants and will be included in annual allocations by next year. Both of these agencies are planning to enhance their ability to improve oral health among pregnant women. //2008//
/2009/ To date, two tribes, Cow Creek and Coquille, have been awarded MCH funds and are pursuing systems building and services related to prevention of early childhood caries. The tribe with the largest membership in Oregon, Confederated Tribes of Warm Springs, have applied for planning funds to plan for prenatal women's health promotion, continue "Back to Boards classes, and home visits for breastfeeding education and early childhood health education. //2009//

/2010/ Oregon's largest tribal government, Confederated Tribes of Warm Springs, has joined the Title V program. Title V services targets a birth cohort of about 156 per year and total MCH population of about 5492 persons. Title V Block Grant funds are directly assisting tribal populations with about $67,000 in infrastructure and population-based funding. //2010//

/2008/ To implement the requirement from the Deficit Reduction Act (DRA) to verify citizenship and identity, Oregon used a unique approach for clients applying for the family planning Medicaid waiver, Family Planning Expansion Project (FPEP). When a client presents for family planning services at one of the participating clinics and does not have proof of citizenship with them, they are allowed a one-time only visit. Using State General Funds, the one-time only visit assures that the provider will be paid for services as long all eligibility criteria are met with the exception of citizenship documentation. The client then can be using a birth control method, with time to bring back the necessary documentation. Since implementing the citizenship verification requirements, visits provided through Oregon's family planning waiver have decreased by 18%. Without the one-time only visits there would have been a 38% decrease. //2008//

/2008/ Legislative summary for health services access:
HB 2867 provides easier access to dental services for patients enrolled in the Women, Infants and Children (WIC) program, the Oregon pre-kindergarten program and Head Start by allowing dental hygienists with specialized training to apply sealants and fluoride without the supervision of

a dentist.
HB 2700 is the ABC - Access to Birth Control - Bill. This bill has two parts: contraceptive equity, which prohibits insurance plans from excluding family planning in prescription medication benefits package; and emergency contraception, which requires hospitals to inform victims of sexual assault about emergency contraception and treatment options and to provide emergency contraception upon request.
HB 3516 Directs Oregon Department of Administrative Services and Department of Human Services to collect data and report to appropriate interim legislative committee regarding citizenship or legal residence requirements for Department of Human Services assistance programs; public assistance as defined in ORS411.010, benefits and services for persons with disabilities, publicly funded or government subsidized housing, food or nutrition programs and unemployment insurance benefits.
SB 362 to expand the Oregon Prescription Drug Program to include the private sector, labor unions, and all underinsured Oregonians who lack full prescription drug coverage. The Oregon Prescription Drug Program was created in 2003 to help low-income uninsured Oregonians over the age of 54 afford the high cost of prescription drugs, through bulk purchasing and pooling resources for the state to negotiate lower prices than what individuals and businesses normally could negotiate. In November 2006, the program was expanded under Ballot Measure 44 to allow all Oregonians without prescription drug coverage to access the program.
HB 2371 requires certain health and child care facilities to adopt emergency plans that provides for safety of persons receiving services from facilities when faced with threat of imminent danger.
SB 571 expands prohibition of smoking in public places and places of employment, with certain exceptions and allowances.
Not passed: HB 3099 requires that water suppliers serving more than 10,000 persons add fluoride to water; delays implementation until water suppliers have sufficient capital to purchase fluoridation equipment; preempts local government regulations that prohibit or restrict use of fluoride. SB 617 to create a traumatic brain injury registry and SB 873 to create a birth defect registry.//2008//
Budget increases in DHS that support health care access (relevant to SPM #6), the 2007 Legislative Approved Budget includes $2 million biennially in expansion of SBHCs to open up to 13 new centers, implement a new quality improvement program, and expand state program office staff in the areas of clinical nursing and health care economic analysis and modeling. //2008// /2009/ The 2008 Oregon Benchmark Race and Ethnicity Report gives a negative rating for decreasing disparities for Native Americans and Hispanic populations in their category for Health and Safety. The report indicates little progress in decreasing the gap of health insurance rates of Native Americans at 28.5% and Oregon's rate overall at 15.5%, in 2006. The gap among Hispanics is 32.7% compared to 13.7% of non-Hispanics. (Oregon Progress Board, May 2008). //2009//

5. Pregnancy, Births and Infants

In 2003, there were 45,935 births, of which 18% were Hispanic. The birth rate for Oregon is 13 per 1,000 population and the infant death rate is 5.6 per 1,000 live births. The teen pregnancy rate in 2003 for ages 15-19 was 49.3 per 1,000 live births. Approximately 57% of deliveries were paid by private health insurance, while approximately 37% were paid by the Oregon Health Plan. Eligibility for the Oregon Health Plan includes children ages 0-18 and pregnant women up to 185% of federal poverty level, while all other adults are eligible up to 133% of federal poverty level, with a co-pay requirement. Dental care is covered for children and pregnant women but not for adults. (Oregon Center for Health Statistics, 2003; http://oregon.gov/ DHS/ph/ chs/ data/ annrep.shtml). In Oregon, SCHIP is seamlessly integrated with the Medicaid program (OHP), making it difficult for the public to distinguish between the two programs.

/2007/ Total births and race/ethnicity of births continues at the same rates. Oregon's low birthweight rates and infant mortality rates are slightly increasing, though still remains less than the national rate. The percentages of women receiving adequate prenatal care is decreasing,

though percentages for first trimester prenatal care continue at the same rate. Outreach efforts to enroll pregnant women early in pregnancy are expanding through the Oregon MothersCare Program. //2007//

/2009/ In general, however, Oregon's trends in low birthweight, infant mortality, and early and adequate prenatal care are declining at the same rate as the rest of the U.S. (see HSCI 05). The disparities between Medicaid populations and the non-Medicaid populations for these indicators are widening and are of concernto the Title V program as well as Oregon's Medicaid providers. The analysis of perinatal data published in the Perinatal Data Book showed results that highlight the need to focus on disparities and inequities to improve birth outcomes. Though the Hispanic population is about 10.2% of the overall Oregon population, the birth rate is about 25 per 1000 women compared to almost 26 per 1000 are Hispanic for all births. Indicators show that Hispanic births are less likely than the state overall to receive early or adequate prenatal care, while African-American births are more likely to be preterm or low birthweight than the state. The infant mortality rates for African Americans (10.5 per 1,000 live births in 2004) and Native Americans (12.8 per 1,000 live births in 2004) are almost double the rate of the state overall (5.4 per 1,000 live births in 2004). //2009//

/2010/ While recent Latina immigrants experience better birth outcomes than the U.S. average, as they assimilate to life in the U.S., their initially higher rates of healthy birth outcomes diminish. In subsequent generations, Latinas' birth outcomes are comparable or worse than rates among U.S.-born whites. To address this paradox, the Oregon Women's Health Program was awarded a grant from the US Health Service Resources Administration (HRSA) to conduct a social marketing campaign targeting Latinas and their providers in five counties, Jackson, Josephine, Douglas, Marion, and Lane. The purpose of the campaign is to raise awareness of Preconception and Inter-conception Health issues among both women and providers. //2010//

/2008/ Legislative Summary for pregnant women and infants:
HB 2372 requires employers with 25 employees or more to provide unpaid rest periods for breastfeeding women to express milk through the day, including requiring employers to provide a reasonable, quiet private location for breastfeeding women.
SB 244 removes the "sunset" clause from the Oregon law statute that states that those involved in criminal/corrections proceedings have the right to request DNA testing to support their innocence. SB 244 also aligns the pieces of Oregon's Genetic Privacy Act that address how genetic information can be retained and disclosed with the federal health information protection law, HIPAA. It eliminates an unintended administrative burden for health care providers, health systems, and patients while leaving in place genetic discrimination protections. These modifications to a portion of the Oregon Genetic Privacy law make it more useable for clinicians and health care systems while still protecting the public from potential genetic discrimination. //2008//

/2009/ The Regional Nurse Team in Oregon's Title V Program collaborated with the Oregon Association of Public Health Nurses, to identify leading priority health issues and develop strategic plans to address these issues. The collaborative identified preconception health and maternal depression as the areas to focus resources and activities over the next couple of years. The outcome is an action plan to address both issues, taking a life-span approach for both issues. The Preconception Work Group used the MMWR Recommendations for preconception health and identified four areas to work on in Oregon: consumer awareness, preventive visits, public health programs and strategies, and monitoring improvement. The Perinatal Depression Work Group developed strategies to work on over the next two years. The areas this group recommends are: partnership development, provider education, screening and referral, research, funding and resource development, mother/infant interventions and programs, and community support services. //2009//

/2010/ The Title V Program in OFH sponsored a symposium on Maternal Mental Health in

March, 2009, that was attended by almost 300 individuals representing 145 organizations across the state. The symposium was the first of its kind in Oregon, and presented information on clinical and public health approaches to perinatal depression. One outgrowth of the symposium was the creation of Oregon Maternal Mental Health Network. The Network's purpose is to enhance the capacity of a broad range of providers to respond to maternal mental health issues by focusing on provider education/support. It will sponsor 3 state-wide networking meetings per year for the next couple of years (Fall, winter, spring) The target participants will be a broad range of stakeholders - especially those interested in provider education/support. Each meeting will address a topic of broad interest to a variety of providers, provide facilitated discussion, networking, and time for professional reflection.

In conjunction with the symposium, technical assistance consultation meetings were delivered by Dr. Laura Miller of UIC for both community and state DHS partners (supported by Title V Technical Assistance). Dr. Miller shared the Illinois model of perinatal system development and assisted participants in exploring opportunities for Oregon. In addition to the Maternal Mental Health symposium, training on identification and treatment of perinatal mood and anxiety disorders was provided in Spring 2009 to Oregon public health nurses.

In the 2009 Legislative Session, two bills were passed related to Maternal Mental Health during this legislative session. HJR 15 was a proclamation of March as Maternal Mental Health month (coinciding with the symposium). HB 2166 is a bill that creates a work group on Maternal Mental Health, appointed by the DHS Director. The work group's task will be to identify vulnerable populations, preventive measures and recommendations for maternal mental health in Oregon for the 2011 legislature.

Another focus of the Oregon perinatal Depression initiative has been the development of a perinatal depression needs and resource assessment tool kit for communities. The tool kit will provide public health departments interested in initiating perinatal depression screening and other related activities with the tools needed to assess their community's needs and resources, link to state level hotline and other supports, engage community partners, and prepare their practice for implementing screening and referral initiatives for perinatal depression. //2010//

/2009/ The Division of Medical Assistance Programs (DMAP) is launching a pilot program that will cover prenatal care to women in two Oregon counties who do not currently have access to these services under Medicaid. The 2007 Legislature approved using federal funds and "other" funds to implement a pilot under the state's SCHIP program. State/county partnerships were established to put together the required financial match to acquire federal SCHIP funds for the project: 73% federal funds, 25% state funds, and 2% county funds. The pilot is for pregnant women residing in Multnomah or Deschutes Counties who are not eligible for any Medical Assistance coverage other than CAWEM (Citizen-Alien Waived Emergent Medical), usually undocumented immigrants, or immigrants with documentation who have not completed their five year US residency requirement. When the pregnancy ends, the mother will return to CAWEM status and the newborn child will be covered for up to a year before eligibility will be re-determined. The pilot is for 15 months, ending June 30, 2009. //2009//

/2010/ The CAWEM pilot project, scheduled through June 2009, in both Multnomah and Deschutes Counties has been extended through September 2009. There is interest in expanding the project to more counties. Specifically, the counties which have expressed interest are Clackamas, Lane, Benton, Hood River, Marion, Umatilla and the Southern Oregon Health Coalition (Jackson, Josephine, and Douglas). //2010//

6. Children and Adolescents

/2008/ The Oregon Health Policy Commission in coordination with the Public Health Division, including OFH and the Chronic Disease Program, prepared a Childhood Obesity Study in coordination to report to the 2007 Legislature. The issue was discussed extensively and number of bills were introduced relevant to reducing both obesity and childhood diabetes. The significant legislation that passed included a ban on junk food in schools, a requirement for employers to have a quiet and private place for breastfeeding mothers, and requirement for a long-term study by the Dept. of Education to recommend and implement changes in physical education requirements by 2011. //2008/

/2008/ Legislation summary for child and adolescent health:
HB 2650 specifies minimum standards for food and beverages sold in public schools during the school day and allows school district boards to adopt more restrictive standards.
HB 2188 expands the ALERT immunization registry from 0 -- 18 to lifespan to age 23 in Phase 1 with current resources and further expansions to take place once funding was secured.
HB 3486 directs DHS to develop a strategic plan to slow the rate of diabetes caused by obesity and other environmental factors in Oregon; to identify actions to be taken to reduce morbidity and mortality from diabetes by the year 2015; and include recommended statutory changes and funding needed for presentation at the 2009 Legislative Session.
SB 480 requires persons who are under eight years of age or are under certain height to use child safety system in motor vehicle and requires persons under one year of age to use rear-facing child safety system.

Dental sealants program was approved with a $300,000 General Fund increase to provide sealants to children statewide. This is the first time state General Funds have supported oral health prevention program. //2008//

/2008/ Governors Executive Order 07-04 created the Children's Wraparound Steering Committee and to develop a statewide plan to provide integrated care for children with, or at risk of developing, significant emotional, behavioral or substance abuse problems. The plan is intended to prevent involvement with foster care and the juvenile justice system; increase academic achievement; provide family and child based services across the public system of care, and maximize availability of resources for appropriate access to behavioral and other support services. //2008//

/2009/ Oregon participated in the ABCD-2 Early Childhood Screening Academy facilitated by the National Academy of State Health Policy, and sponsored by the Commonwealth Fund. The Title V Program at the Office of Family Health provided leadership and project management in partnership with the Oregon Pediatric Society and the Division of Medical Assistance Programs (Medicaid agency) and the Oregon Center for Children and Youth with Special Health Needs. Within the last year, the Oregon ABCD Coalition has created recommendations for standardized screening tools for development, behavioral and psychosocial screening; improved the placement of the screening CPT code 96110 in the Oregon Health Plan to encourage its use in conjunction with screening, and is improving the referral communication between providers and early intervention services. In the Fall, 2008, the Initiative is supporting a demonstration site at Kaiser Permanente Northwest pediatric clinics to integrate standardized developmental screening tools in well child visits. Additionally, efforts are underway to spread the practice of standardized screening through partnerships with a managed care organization, CareOregon, and the Northwest Early Childhood Institute to implement a train-the-trainer curriculum on screening, and more providers are interested to learn and implement screening in their practices. //2009//

/2009/ Oregon developed a booklet aimed at promoting the comprehensive adolescent well visit. The booklet is aimed at (1) parents of youth ages 11 -- 15; and (2) the youth themselves. It provides information about how providers can be helpful to parents in discussing health risks (substance use, sexual activity, etc.) at the well visit, and can be a time for youth themselves to bring up health issues of concern to them. The piece also provides information on adolescent

brain development and Oregon is in the middle of an evaluation to see if the booklet had any effect on well visit rates in an Independent Physician Association's practice where the booklets were mailed to all eligible parents. //2009//

/2010/ The Title V Program plans to develop children's health priorities in partnership with the Association of Oregon Public Health Nurse Supervisors, following the template of planning and implementation process as those for maternal depression and preconception health. A Child Health Summit is being planned for November 2009. //2010//

/2010/ Legislation was passed (HB 3022) to permit Expedited Partner Therapy (EPT) that allows dispensation of antibiotics for partners of individuals infected with sexually transmitted diseases, when the partner has not been able to perform an exam on the partner. Professional health regulatory boards may amend their practice standards to allow EPT by their licensed practitioners. //2010//

7. Services to Children with Special Health Needs
It is estimated that 13% to 18% of Oregon children under the age of 21 years have special health needs. Significant advances in science and technology have reduced the risk of mortality for CSHCN; this has simultaneously resulted in an increase in morbidity due to chronic illnesses. More youth and young adults with disabilities are living longer and assuming productive lives. Fewer than 30% of young adults with special health needs are employed. They may have no experience managing their own health and are unaware of resources that could help them.

In Oregon, it is estimated that 116,364 children have a special health need, and 5,818 of these children have a condition so severe that it significantly interferes with day-to-day function. Children with cerebral palsy, autism, arthritis, Down syndrome, ADHD, rare metabolic disorders, spina bifida, cleft lip and palate, and mental and behavioral disorders represent the diversity of the population e served by the Title V CSHCN program.

/2007/ The total number of children in Oregon age 0-17 years dropped slightly in 2005 to 865,613. Based on the National Survey of CSHCN the estimated number of children with special needs in Oregon is 115,473, and of these 6%, or 6,928 children would have a disability significant that impacts their ability to function at an age appropriate level. //2007//

/2010/ Data from the 2005/2006 NS-CSHCN estimates 13.3 percent (116,988) of children in Oregon have one or more special health care needs. The survey estimates that 11.2 percent of Oregon CSHCN ages 0 to 17 were without health insurance at some point in the prior year. This same figure was estimated to be 15.4 percent using data from the 2001 NS-CSHCN. Approximately 22 percent (103,678) households in Oregon have one or more CSHCN. Sixteen percent of these children were non-white and 11 percent were of Hispanic ethnicity. In comparison, data from the US Census Current Population Survey (CPS) from the same time frame estimate that 18.4 percent of children 0-17 in Oregon were non-white and 15.7 percent were Hispanic. Nearly 45 percent of CSHCN in Oregon were members of households with incomes below the Federal Poverty Level (FPL) (16.8 percent) or less than 200 percent of the FPL (26.4 percent). Estimates from the CPS indicate 39 percent of children ages 0-17 lived in households with incomes below the FPL (16 percent) or less than 200 percent of the FPL (23 percent). Over one quarter of CSHCN in Oregon (27.5 percent) lived in geographic areas classified as Large Towns or Small Towns/Rural. These areas are located predominantly in the rural or frontier counties in the central and eastern regions of the state. //2010//

/2010/ Oregon does not currently have a birth anomalies registry. Children with risk factors or conditions that are receiving services through the Care Coordination program (CaCoon), however, are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY '09 were developmental

delay, congenital heart disease, genetic disorders, oral motor dysfunction and other chronic conditions. Children can have more than one risk factor recorded; during FY 09, approximately 66% of children in the CaCoon program had multiple risk factors. Several additional risk factors were added to the database during the current year including fetal alcohol syndrome, Autism spectrum disorder, and behavioral or mental health disorders that are coexisting with developmental delays. Over past several years, Oregon initiated a surveillance system for fetal alcohol spectrum disorders (FASD) in the Office of Family Health. Data from this system are currently being compiled and analyzed. //2010//

/2010/ Every child in Oregon identified as in need of special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act (IDEA). In 2008, 2,590 children received early intervention (EI) services. In Oregon, children must have an established diagnosis of developmental delay in order to receive EI services; children who are at risk of developmental delay are not served. Oregon does not track the number of children who have 504 plans at school. //2010//

It is estimated that the Hispanic population in Oregon has increased 12% since the 2000 Census. OCCYSHN recognizes the impact this growth has on community based services and has responded with continued support of Promotoras in the CaCoon Program, Spanish translation of materials and inclusion of interpreter services in outreach forums in FISHS grant and the Oregon Medical Home Program, and a bi-lingual Spanish support staff in the Title V Office. In some counties more than 50% of the families followed by the nurses are of Hispanic origin.
• The number of children enrolled in the Oregon Health Plan is 224,529 (birth to 18 years of age). During 2004, 229,000 children, 0-20 years of age, were enrolled approximately 10% or 2,290 of those children are reported to be blind or disabled or in foster homes.
• During 2003, 74% of the services provided by CaCoon were to children insured through Medicaid. According to the Social Security Administration December report 7,508 children under 18 years of age received SSI and were eligible for Medicaid. CDRC continued the agreement with DDS to provide evaluations to determine SSI eligibility. The Portland CDRC provided 54 assessments to 48 children. Evaluations included 26 pediatric, 9 psychology, 9 special education, 7 speech, 1 ENT, 1 audiologist and 1 occupation therapy. The Eugene CDRC provided 49 evaluations to 44 patients: 21 speech, 11 pediatric and 17 psychology.

/2007/ In 2005, 6,832 children under the age of 16 received federally administered SSI payments. The majority of these children lived in their parent's household and according to the Office for Seniors and Developmental Disabilities Services, up to 50 children receiving SSI benefits resided in a long-term care facilities or Medicaid institutions. In 2005, the total number of Oregon children, age 0-21, in special education is 79,913.
//2007//

/2010/ The Oregon Commission on Autism Spectrum Disorder was created by Executive Order of the Governor. The commission is charged with developing and monitoring the implementation of a ten-year strategic plan to address services for individuals with autism, engaging stakeholders, setting priorities, and proposing legislation. Several key pieces of autism legislation are pending.

Work continues through the Addictions and Mental Health Division (AMH), Division of Medical Assistance Programs (DMAP), and the Public Health Division (PHD) to work with community partners to integrate behavioral health and primary care. The concept of medical home is strengthening throughout the state and through health care reform. Two community health collaboratives received grants from DHS in the amount of $250,000 to develop innovative ways to improve access to health care for low-income and vulnerable populations. One collaborative is implementing medical home for CYSHN.

Summary of Legislation impacting CYSHN:
HB 381 requires health benefit plans to provide coverage of medically necessary treatment

of traumatic brain injury.
SB 9 requires health insurance coverage of treatment of inborn errors of metabolism.
HB 3418 requires DHS to determine feasibility of implementation of a system for reimbursement for health care delivered through an integrated health home (medical home) model and to apply to CMS for any necessary approval.
HB 2144 requires state agencies and commissions to participate in wraparound initiative for the provision of youth services.
HB 2589 requires commercial health insurance plans that are regulated by Oregon to pay for hearing aids for children. The plans will reimburse up to $4000 every 4 years for a covered child. A consultant in the OCCYSHN office was instrumental in educating legislators about the positive impact of this coverage.
//2010//

B. Agency Capacity

The Title V Agency for Oregon is the Office of Family Health (OFH) in the Department of Human Services, located in Portland, Oregon. The Title V Program for Children with Special Health Needs (CYSHN) is administered through the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), at the Child Development and Rehabilitation Center (CDRC), in the Oregon Health and Science University (OHSU). Oregon Revised Statutes (ORS) 444.010, 444.020 and 444.030, designates OHSU as the authority to administer services for children with special health needs. CDRC is a division of OHSU, a tertiary care clinical program and the Oregon Institute on Disability and Development (OIDD) which is one of 61 ***/2010/ now 67 //2010//*** University Centers for Excellence in Developmental Disabilities (UCEDD).

The Title V Program in Public Health and the Title V Program for CYSHN have an interagency agreement to document the roles of each agency and to directly transfer 30% of the Title V allocation (without indirect costs). The two organizations strive to have a seamless collaboration and coordination to provide state and local services for whole Title V population.

The mission of the DHS, Office of Family Health is to provide leadership for improving health outcomes for women, children, and families through:
1. Collecting and sharing data to assess the health of women, children, and families;
2. Developing and implementing public health policy based on these data;
3. Assuring the availability, quality and accessibility of health services and health promotion; and,
4. Providing technical assistance, consultation, and resources to local health departments, and other community partners.

The OFH programs provide the capacity to provide primary and preventive care to the Oregon's MCH population. Program activities typically include systems development, infrastructure, technical assistance, training, and resources to local and state organizations working to improve health of the MCH population. The programs are organized into sections that report directly to the Title V Director/OFH Administrator.

The mission of OCCYSHN is to improve the health, development, and well-being of children and youth with special health needs, through the following activities:
• Partner with families, communities, providers and agencies
• Provide leadership in policy development, advocacy and assessing levels of care and services;
• Support efforts to coordinate and maximize resources;
• Work with communities to strengthen their capacity to meet the needs of children and their families;
• Honor the strengths and diversity of families.

Capacity for Preventive and Primary Care for Women, Children and Adolescents:
Office of Family Health, Public Health Division

Title V Coordination
- MCH Program Specialist: provides technical assistance, consultation and coordination for MCH policy and assessment issues and activities, including local MCH program assessment, planning, and evaluation, legislative analysis and development, and coordination of the Title V Block Grant.
- Medical Consultant: provides medical consultation, expertise, and on family health issue, disease prevention, and genetics to professional staff on specific services and program components related to the identified areas, and serves as the Office of Family Health's liaison with the State's primary care providers.

Women's and Reproductive Health Section: The Reproductive Health Program assures reproductive health services are available across the state; provides funding and technical assistance to local family planning clinics that offer contraceptive services and screening for breast and cervical cancer, infections, anemia, and other conditions; administers a family planning benefit program for low-income Oregonians, Family Planning Expansion Project (FPEP), under a HCFA 1115 waiver; and promotes awareness of women's health issues among the public and health providers. Title X and Title V funding supports family planning services to individuals not eligible for FPEP. Women's Health Program: A systems development program to raise awareness, engage stakeholders, and improve resources for women's health concerns across the lifespan.
- The Women's Health Program includes three major efforts: A Women's Health Initiative funded by Office of Women's Health in HRSA is being used to 1) expand the information and referral capacity of the MCH Toll-Free line (SafeNet) and improve the information and referral resources for the public and for providers, 2) identify gaps in services and data identified by SafeNet call data, and 3) create a statewide women's health coalition.
- A CDC Rape Prevention and Education Grant supports the Oregon Sexual Assault Task Force to provide funding and technical assistance to local agencies around primary prevention of sexual assault. /2007/ Two statewide plans were released in May, 2006. The first, "Recommendations to Prevent Sexual Violence in Oregon: A Plan of Action," was a joint effort between Women's Health and the Attorney General's Sexual Assault Task Force; the second, "The Oregon Violence Against Women Plan," was produced by the Injury Prevention Program. //2007//
- Fetal Alcohol Syndrome (FAS) Prevention Project is a CDC grant to prevent alcohol use among women of reproductive age. The FAS Project has three parts: 1) Design and implement an intervention to identify women who are at high risk for having a child with FAS and refer them to appropriate services in family planning, university, and Indian health clinics, 2) Use surveillance techniques to identify the prevalence of FAS children in Oregon, and 3) Develop systems to improve the referral of children with FAS and their families to appropriate services. ***/2010/ The FAS program is phasing out, while the Womens Health Program has applied for a new CDC- FAS grant for surveillance. //2010//***
/2009/ The Oregon Breast and Cervical Cancer Program moved to the Women's and Reproduction Health Section in 2007, from the Office of Prevention and Epidemiology. The BCC Program helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCC Program provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals. Each year, approximately 7,000 eligible individuals receive services. Funding is from Centers for Disease Control and Prevention and the Susan G. Komen for the Cure Oregon and SW Washington Affiliate. //2009//

/2010/ Colorectal Screening Grant is to establish and integrate evidence-based colorectal cancer screening programs with existing screening programs and/or other cancer screening programs like Oregon's Breast and Cervical Cancer and WISEWOMAN Programs. The majority of the funds will be used to reimburse health care providers on a fee for service basis for office visits and colorectal cancer screenings for low-income,

uninsured Oregonians. The Grant begins July1, 2009 and funding is for five years from CDC. //2010//

Maternal and Child Health Section:
/2009/ New section beginning October, 2008, merging previously stand-alone programs in Office of Family Health including perinatal health, child health, EHDI, oral health and nutrition. Added an evaluation and assessment unit to support program evaluation in the section. //2009//
Perinatal Health Programs seek to improve the health of pregnant women and birth outcomes through promotion of optimal prenatal care and other pregnancy related services for all pregnant women. This section uses Title V resources to develop statewide policy and funding for improving the health of periconceptual and pregnant women. Activities include: supporting local health departments to plan, manage and deliver perinatal services including outreach, advocacy, systems development, the Maternity Case Management program, community-based health education; early prenatal care and insurance coverage through the Oregon MothersCare program; and administering the Pregnancy Risk Assessment Monitoring System (PRAMS).
Perinatal health programs include:
- Maternity Case Management (MCM) program is administered through county health departments either by direct service or by contract. Services are reimbursed through the Oregon Health Plan (Oregon's Medicaid Waiver Health Plan) serving women up to 185% of federal poverty level. Services include screening for risk factors, referrals for supporting health care and services, smoking cessation counseling and follow up, and ongoing support and advocacy prenatally and two months postpartum.
- Oregon MothersCare (OMC) program is an information and referral resource for all pregnant women and providers. By streamlining state and local systems, OMC facilitates enrollment in the Oregon Health Plan, the scheduling of the first prenatal care appointment with a local provider as early as possible in the pregnancy, and referral to MCM, WIC, and other services as indicated. The program is funded through Title V funds in addition to local funding.
- SHEEP Project (Safe Home Environment for Every Pregnancy) is a joint project between OFH/Title V and the Oregon Office of Environmental Toxicology working on an Environmental Protection Agency Grant, "Expanding Capacity to Address Environmental Exposures During Pregnancy", through December 2009. The pilot sites are the Maternity Case Management programs in Deschutes and Hood River County Health Departments and are creating a screening tool for home environmental hazards for children and pregnant women.
- MCH System and Policy Specialist: Provides coordination and leadership in planning and coordinating strategies and policies for implementation at the state and local levels.

Child Health Programs promote optimal health, safety, and well-being of all infants and children in Oregon through preventive practices and strategies along a developmental continuum of growth and development from birth to adolescence. This section uses Title V resources to develop statewide policies and programs for child health improvement including: coordinating local public health nurse home visits through the Babies First! Program; providing statewide training and technical assistance for promotion of nutrition, breastfeeding, and physical activity; developing integrated data systems for services for children and children with special health needs; and promoting healthy child care practices. Programs in the Child Health Section include:
- Early Hearing Detection and Intervention Program: This program promotes early detection of hearing loss among newborns through follow-up and referral to early intervention services, funded by a HRSA-SPRANS grant. State laws adopted in 2000 mandates all hospitals with more than 200 live births per year to provide hearing screening tests to all babies born in their hospitals. A hearing registry, hi-track system and recall system is functional as of 2007.
- Babies First! Program: A high-risk infant nurse home visiting program delivered through county health departments which assures healthy growth and development of infants and children up to age 5. The Office of Family Health allocates state general funds and counties are reimbursed through target case management billing. Title V funds support these services for activities and individuals not eligible for Babies First! services.
- Child Care Health Consultation Program: A program that educates and trains certified facility

and family-based child care providers in health and safety practices, nutrition promotion, communicable disease prevention, physical, social and emotional growth and development screening, and community resources. This program is funded through a combination of funding from the State Child Care Division and Title V funds. /2009/Program is fully operating in four sites with planning underway to expand into four regions and will strengthen the mental health consultation component.//2009//
- Regional Nurse Consultation: The state nursing staff provide technical assistance, consultation and training to local public health nurses in implementation of MCM, OMC and Babies First! programs.
- Children with Heritable Conditions: A HRSA-SPRANS funded project that will integrate client data systems with newborn screening and birth certificate data, in FamilyNet, Oregon's integrated data system that includes WIC, Immunization, Prenatal, High Risk Infant programs, CaCoon (Oregon's CSHCN home visiting program), newborn screening, and birth certificates.

- Oral Health Program seeks to improve the oral health status of all Oregonians through statewide planning, policy and program development, data surveillance system, and to make progress on the oral health status of Oregonians. A State Oral Health Coalition is implementing the State Oral Health Plan (rolled out in 2006), addressing five focus areas across the lifespan: oral health education/promotion, prevention, access, workforce, and infrastructure, including special populations and optimal water fluoridation. The Oral Health programs include oral health infrastructure development, policy development for fluoridated community water systems, school-based sealant programs, school-based fluoride supplement program, and an early childhood cavities prevention program. Title V provides resources for public health dentist consultant and the fluoride supplement program. Funding from HRSA provides for dental sealant projects across Oregon and a CDC cooperative agreement is funding oral health infrastructure planning and implementation.
- Early Childhood Systems Planning: Oregon's Early Childhood Comprehensive Systems Initiative coordinates integration of early childhood policies and strategies within existing activities and programs. The project works closely with all Title V programs in OFH and OCCYSHN, and the Commission for Children and Families, the Oregon Mental Health and Addiction Services, Child Care Division, Child Protective Services, and Early Intervention services in the Oregon Dept. of Education. /2007/ The State Early Childhood Plan sets out priorities to strengthen overall infrastructure and capacity in each of the five critical components of the early childhood system. In 2006-2007, Oregon will begin to implement strategies in six action areas and facilitate development of a public-private partnership. //2007//
/2009/ In 2007-08, the ECCS attained new levels of partnership and momentum for comprehensive systems development. Governor Kulongoski health a Governor's Summit on Early Childhood in March, 2008, and launched " Early Childhood Matters: Oregon's Framework for A Birth through Five Early Childhood System." This framework was based on the state's ECCS plan and reframes that plan into three core elements: Health Matters; Early Learning Matters; and Family Matters. The state ECCS Program will continue involvement with the Early Childhood Council, co-sponsor of the Health Matters sub-committee, and facilitation of the system indicators workgroup. The OCCYSHN Program participated in the Governor's Summit and will participate in the "Early Childhood Matters" activities. //2009//

/2010/ The ECCS grant for 2009-2012 was submitted and approved. The grant coordinator will continue to work with the Early Childhood Council. One of the overall goals for this next grant period will be to create a state DHS workgroup to work on common early childhood issues and policies. This will include representatives of the foster care and child protective services, mental health services, and Medicaid/Oregon Health Plan. The participation of some of these agencies with the ECCS project or the statewide initiatives (with the exception of mental health services), has been limited or inconsistent. There is an increasing need to align activities, programs and policies to implement recommendations and policies that arise from the Early Childhood Matters committees and Council. The workgroup will be convened in the next few months. //2010//

/2008/ Evaluation and Epidemiology: In 2007, OFH piloted use of program evaluation consultation through with the state pubic health Program Design and Evaluation Services. The AMCHP-Data Grant helped support this activity, and the products include guidelines to program evaluation specific to OFH programs. Below is a summary of this new section in OFH. //2008//
A consultation group provides leadership, systems building, and technical assistance to OFH and CSHCN Title V state and local programs. Includes:
- MCH Epidemiology: provides consultation and surveillance to OFH programs and state and local organizations; conducts research and studies of PRAMS to determine trends and gaps in the health status of pregnant women and newborns.
- MCH Data Coordinator /2008/ Position changed to MCH Informatics//2008//: provides statistics and epidemiologic consultation, technical assistance and leadership in developing the integrated/linked client data system, FamilyNet, and its Family and Child Module. This position also creates, monitors performance and outcome measures for Title V, OFH, DHS, programs, and provides consultation and training to state and local organizations on using of data in policy and program development and evaluation.
/2009/ The MCH Evaluation Unit Manager began in May, 2008, with the primary activity to organize and build a viable program evaluation and epidemiologic unit over the next few years. //2009//
/2009/ In the summer of 2007 The Office of Family Health released a new data system designed to gather data for Oregon's public health home visitation programs. OFH successfully partnered with county health departments to assure uniform data collection state-wide. Data analysis from Oregon's Maternal Child Health Data System (ORCHIDS) is underway and the completion of a report is projected for January 2009. This data will be used to evaluate the current home visiting continuum and will help inform future program evaluation and planning. For the first time in Oregon history, Oregon's public health home visitation program data is collected in one uniform data base. This same data base is linked to Oregon's WIC and Immunization program databases. //2009//

/2010/ The MCH Assessment and Evaluation Unit is now fully staffed. The unit will lead the 2010 Title V Needs Assessment and will build capacity to conduct ongoing assessment, focus groups, public health data analysis and other studies. //2010//

/2009/As of May 2008, the ORegon Child Health Information Data System, Maternal and Child Health Data Entry (ORCHIDS-MDE) system is being used in all but 1 county. ORCHIDS data is being integrated into the existing FamilyNet data warehouse. //2009//

Adolescent Health and Genomics Section: The goal of the adolescent health section is to maximize the health and functioning of Oregon's adolescent population. The section includes teen pregnancy prevention, nutrition & physical activity, school-based health centers, and coordinated school health programs. Title V funds are directed at leadership and policy development activities at the state level, health promotion activities and infrastructure development in county health departments, and ongoing assessment, data collection and technical assistance for implementing statewide policies and programs related to adolescent health at the local level.
- Adolescent Health is a working member of Oregon's Department of Human Services Teen Pregnancy Prevention Program/ Sexual Health Partnership that provides technical assistance to public and private partners and local coalitions working on a statewide Teen Pregnancy Prevention Action Agenda. The Title V Abstinence Education program is administered through TANF in the Children, Adult and Families Services Division in DHS as one strategy within the state Action Agenda
- The School Based Health Center (SBHC) Program coordinates the development of SBHCs through county health departments as a component of the state's safety net system of care for school-aged youth. The program provides technical assistance to local communities for planning, operating, and certifying SBHCs and maintaining a statewide database on services. School-Based Health Centers are funded through a combination of state general funds, Title V and local funds. The SBHC program supported a successful application to the Kellogg Foundation from the

State SBHC Coalition for a 5-year organizational grant to advance community level sustainability and advocacy efforts. //2008/ The Legislature approved $2M in SBHC expansion. //2008// /2009/ The SBHC expansion began in Fall 2007 and continues. See more information in State Performance Measure #6 narratives. //2009//
- The Healthy Kids Learn Better (Coordinated School Health) Program, funded by CDC represents a key state-level partnership with the Oregon Department of Education that supports implementation of the coordinated school health systemic change model and framework at the local school level to address health-related barriers (e.g. nutrition, physical activity, tobacco) to learning and educational success. There are 22 individual projects in development at the state level combined with the external supports for local and state policy changes through the statewide Healthy Kids Learn Better Coalition representing over 40 statewide organizations. /2007/ In 2006, 13 new sites will are planned, 5 of which who will focus on tobacco, physical activity & nutrition, 4 on asthma. A new HRSA funded initiative provides resources for schools to apply for funding to focus on mental health issues in their school using the Coordinated School Health model and will add 4 additional projects. //2007// /2008/ A mental health component was added to the Coordinated School Health program for the 2006-07 school year. A school mental health self-assessment and planning tool was modeled after the CDC School Health Index, piloted during the 2006-2007 academic year. //2008// /2009/ The CDC did not fund Oregon for the next Cooperative Agreement for this project. The Public Health Division is continuing as the lead agency for HKLB and is restructuring support in partnership with the Office of Disease Prevention and Epidemiology. The mental health project is continuing with leveraged funds from the Addictions and Mental Health Division in DHS to continue development of the innovative approach to include a mental health as a topic area in the Coordinated School Health program. The loss of funding for the Physical Activity and Nutrition program is also impacting the CSH program planning within public health. The tobacco program and state general funds are funding the HKLB program for now. //2009// ***/2010/ Title V and tobacco funds will continue support of the Healthy Kids Learn Better Program //2010//***

Genomics Program: Oregon's Genomics Program is completing the second year of a 5 year CDC implementation based on the development of the Oregon Strategic Plan for Genetics & Public Health. Activities include: a Public Health Genetics Symposium; support for revisions to Oregon genetics privacy statute through staffing of the state Advisory Committee on Genetics Privacy and Research; establish and expand surveillance questions on key state surveys; initiate two projects related to family history & genetics; complete research synthesis on Genetics and Diabetes and Genetics and Obesity; include genetics in statewide chronic disease prevention plans and health communications. /2007/ In 2005, revisions were made (SB1025) in Oregon's genetic privacy and research laws that went into effect in 2006 that required the Genetics program to write administrative rules and development health communications for providers, consumers, IRB members and researchers that allows an ‘opt-out' provision for anonymous and coded genetic research. //2007// /2008/ The 2007 Legislature made modifications to Oregon Genetic Privacy law make it more useable for clinicians and health care systems while still protecting the public from potential genetic discrimination. //2008//

Immunization Section: The Immunization program provides leadership in preventing vaccine-preventable diseases by reaching and maintaining high lifetime immunization rates. Activities include implementing Oregon's school immunization law; administering funding to local health departments and migrant health centers for child immunizations; operating Oregon's Immunization ALERT registry to track vaccinations provided in public and private health provider settings; providing free vaccines to public and private providers for children aged birth through 18 in certain population groups; coordinating a WIC-Immunization integration project for low income infants and children; providing technical assistance to private and public providers through AFIX, a continuous improvement method for improving clinic practices to achieve high immunization levels; promoting and providing technical assistance to increase immunizations to adolescents and adults. ***/2010/ The Immunization program is implementing a new Information System that integrates the Alert registry and IRIS public health client data. //2010//***

Women, Infants and Children (WIC) Section: The Oregon Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a public health nutrition program funded by the US Department of Agriculture (USDA) designed to improve health outcomes and influence lifetime nutrition and health behaviors in a targeted, at risk population. The program contracts with 34 local health agencies to provide WIC services to over 109,000 pregnant and postpartum women, infants, and preschool children each month in all geographical areas of the state. WIC contracts with farmers and farmers' markets to provide coupons to participants to promote fresh fruits and vegetables. /2009/ WIC is also the recipient of two national research grants from USDA to test strategies to increase duration of breastfeeding and consumption of fruits and vegetables. The data system, TWIST, provides important data to identify trends and risk factors to better target nutrition education and assistance to the WIC-eligible women, infant and child population. Both WIC research grant are progressing as planned. The breastfeeding grant is in its 3rd and final year and results should be available by the end of 2008. The fruit and vegetables research study is testing an educational approach using motivational interviewing three local agency sites. Early feedback indicates this technique to be highly popular and perceived by local staff as being a more effective way of counseling clients.//2009//

Capacity for Preventive and Primary Care for Children with Special Health Needs:
Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)
OCCYSHN-Title V Programs ensure a statewide system of services reflecting comprehensive, community-based, coordinated and culturally competent family-centered care.

/2010/ CDRC and OCCYSHN is facing significant reductions in its state general fund supports and will be redesigning its structure to continue serving the Title V CYSHN populations. The Child Development and Rehabilitation Center clinic programs and the OCCYSHN will develop a partnership that will essentially re-assign Title V funds. A new program will be developed and implemented with the goal to integrate CDRC's clinical activities with public health activities that benefit children with disabilities and complex conditions throughout Oregon. Outcomes for this refined effort are expected to improve efficiencies in policy, systems of care, provider and parent preparation in the care of CYSHN. Areas of the new integrated clinical and public health program include emphasis on care coordination, behavioral health, medical consultation in developmental pediatrics with specialty emphasis on autism, genetics and high risk infant care and follow-up. This effort is being designed to benefit children at the local level and through systems change at the state level. Activities that are clinic based will be leveraged to provide community-based outreach clinics to better meet the needs of CYSHN at the local level. //2010//

OCCYSHN programs include:

- Community Connections Network - in 14 primarily rural communities implement multidisciplinary teams of health, educational and social service professionals which evaluate and coordinate services for CYSHN and their families, develop care plans and participate in community planning activities to increase the organization and capacity of community based services and community based providers who provide services to CYSHN

/2010/ OCCYSHN will reduce the number of community based CCN teams to within available budget as well as a corresponding reduction of internal community consultant staffing. Efforts are targeted to providing full support of a reduced number of rural community-based interdisciplinary teams. //2010//

- CaCoon (Care Coordination) Program - in all of Oregon's 36 counties, specially trained public health nurses help families and children develop management skills, (for example, feeding an infant with cleft lip/palate); work with health professionals and families to identify needs, gather resource information and refer to appropriate services; and participate on community planning groups, for example, Local Interagency Coordinating Councils for Early Intervention.

/2010/ Funding for the contracts with local public health departments for the Cacoon program will be reduced by 10% along with reduction of OCCYSHN Nursing Consultant time to support and monitor the program. Given economic realities and other reductions experienced at the local level, OCCYSHN is working with the Oregon county health nurse supervisors to ascertain the best way to reallocate funding. //2010//

- Family Support Program -- limited funds available to CYSHN and their families who reside in Oregon to purchase supplies, equipment, and other needed services not covered by health insurance.

/2010/ The Family Support Program will be suspended starting July 2009 due to reallocation of OCCYSHN funding and the need to re-evaluate program operations and administration procedures. Administrative costs to implement the program have become challenging. Coupled with the reduction in funds available for this activity, it is necessary to re-evaluate the feasibility of the program. //2010//

- Family Involvement Network (FIN) is a statewide network of CYSHN families who Provide parent perspectives across OCCYSHN and CDRC activities, family supports to CCN teams, train parents on working with health professionals and on multi-disciplinary teams. The OCCYSHN FIN program has 3 parent consultants, one of whom sits on the management team, and participates in planning and policy development across the Title V program in both offices.

/2010/ The FIN consultant staffing pattern has been reduced to 1 half-time (0.50) parent consultant. Support to the family liaisons who are community-based will be maintained. //2010//

- Grants and contracts focus on the development of training materials and provision of training events, development of model programs, and support for community-based activities.
- Office of Program Evaluation and Research (OPER) provides OCCYSHN's evaluation and epidemiology consultation. This supports OCCYSHN's commitment to continuous program improvement, assessment of program effectiveness and CYSHN population health monitoring.
/2008/ OPER is staffed with a Program Evaluator/Director, Epidemiologist, Biostatistician, Database Systems Analyst, and Qualitative Research Methodologist who also serves as the Clinical Research Coordinator, a Research Assistant, and Graduate Research Assistants. Additional consultation is accessible through the Child and Adolescent Health Measurement Initiative (CAHMI) housed within the OHSU Department of Pediatrics. CAHMI is nationally recognized for its work with the National Survey of Children and the National Survey of Children with Special Health Care Needs dataset and making it accessible through www.cshcndata.org. //2008//
/2009/ Dr. Elizabeth Adams, MCH Epidemiologist, directs the Office of Program Evaluation and Research. It is staffed with a health systems researcher, an evaluation specialist, a database analyst and several research assistants. FY09 calls for increasing OCCYSHN's capacity in data management, analysis and reporting. //2009//

/2010/ During FY09 the Oregon Center for Children and Youth with Special Health Needs hired onto its staff directly an Evaluation and Research Consultant, Dr. Lisa Lymans. OCCYSHN maintains a relationship with OPER for other supporting evaluation assistance and epidemiological consultation.

OCCYSHN continues its collaborative partnership with the Child and Adolescent Heaalt Measurement Initiative (CAHMI) through a shared effort with the ABCD Collaborative and in relation to surveillance activities in partnership with the Office of Family Health through the PRAMS 2 Survey. Additionally, CAHMI provided training to OCCYSHN staff to increase its capacity for using NS-CSHCN data in its community-based program activities.

OCCYSHN partners with the Oregon Office on Disability and Health in relation to its support and analysis of the BRFFS and Oregon Health Teen Surveys. //2010//

- Other agency capacity includes support for community professionals with best practice, resource and referral information; develop and coordinate training programs for community professionals; and work with key state partners, for example, major hospitals throughout the state to facilitate the referral of children and families to appropriate local services after hospital discharge.

The Oregon Institute of Developmental Disabilities, a University Center for Excellence in Disability and Development, houses the Leadership Excellence in Neuro-developmental Disabilities (LEND) training program, the Oregon Office on Disability and Health (OODH), and the Center on Self Determination (CSD). LEND trainees regularly participate in Title V activities, including direct clinical services in CCN clinics, making referrals to CaCoon nurses, and consulting with nursing staff about the clinical problems of individual children. The OODH is one of 16 centers nationally that receive funding from the Centers for Disease Control and Prevention (CDC) which supports activities to improve the health and wellness of people with disabilities. The Center on Self Determination exist to identify, develop, validate and communicate policies that promote the self-determination of people with disabilities.

Community Integration of the CYSHN Programs: A Community-based Service System Task Force, chaired by Dr. Dale Garrell, completed a report in 2004, "Toward a State-wide Community Based System of Care: An Integrated Approach to Care by the CDRC's Title V Services." The task force recommended the identification of a single point of referral for OCCYSHN services in the community and to integrate the supports provided to CaCoon nurses and CCN team members. County participation in the Universal Application System for Oregon (an activity of the FISH's grant) will allow for common eligibility for families for CSHN programs and direct them to a single point of contact in communities such as the local CaCoon program. /2008/ The Universal Application System was piloted in a few counties; however the response rate was too low to evaluate effectiveness. //2008//
- Videoconferencing is used extensively by the OCCYSHN and OFH to provide training, meeting access, and learning collaborative work.
- Coordination among CDRC Clinics and the OIDD includes tertiary care clinics in Eugene and Portland and outreach clinic sites in Medford, Klamath Falls and Roseburg. Interdisciplinary teams and individual clinicians provide diagnostic assessments, consultation, and management for children and youth with established or suspected disabilities. Some of the clinical programs are "unique" in the state such as the Metabolic program, and the services offered by other programs are partially duplicated at other centers. The clinical programs include the Metabolic, Genetic, Craniofacial, Spina Bifida, Neuro-developmental, Child Development and Autism programs. In 2005, 6452 CYSHN received 32056 services in these clinics. Relationships between the OCYSHN and clinicians are critically important to the support provided to individual children and families. Joint quality improvement projects are conducted with the clinics and involved the specialists in needs assessment of direct services.
- /2008/ In 2006, 6,962 CYSHN received 37,414 services in these clinics.

/2008/ CDRC was named a University Centers for Excellence in Developmental Disabilities (UCEDD) as an agency, thus moving the UCEDD from a project to a program within CDRC. This change in organizational status will align the OCCYSHN to the mission and goals of excellence in education, research and service in the field of developmental disabilities as well as linked to a national network of centers. The UCEDD centers work with people with disabilities, their families, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing, with a focus on building the capacity of communities to sustain all their citizens. These activities will further support and strengthen OCCYSHN's capacity to address the needs of children with special health needs and their families across Oregon. OCCYSHN will maintain its unique program identity, internal administrative and programmatic structure, and program budget. //2008//

- Relationships to Other OHSU Departments: OHSU faculty present at CDRC conferences and provide consultation to CCN community teams. School of Nursing faculty provide training for CaCoon home visiting nurses and participated in the development of the PHN training modules. Support for distance learning is available through the Biomedical Information and Communication Center (BICC) and the Information Technology (IT) office at OHSU. The BICC regularly transmits distance-learning activities of the School of Nursing and OHSU's Area Health Education Centers (AHEC). Work has begun with staff from the Oregon Rural-based Practice Research Network (ORPRN), the Office of Rural Health (ORH), and the Center on Health Care Disparities at the School of Nursing. The ORPRN includes 28 practices scattered throughout the rural areas of Oregon, and staff from the ORH have facilitated community-planning groups on health care issues in many of the same areas of the state.
/2007/ Partnerships with the Leadership Education in Neurodevelopment and other Disabilities (LEND) has been strengthened with the agreement to incorporate the community-based services programs as training sites for LEND trainees. Disciplines of nursing, social work and psychology participated in the community-based teams and conducted family satisfaction survey as part of the Continuous Quality Improvement efforts. The LEND program has incorporated family professional partnership into its curriculum and partners with OCCYSHN's family staff to implement FPP and family centered care.
- Partnerships within the OHSU departments, including CDRC, provide an opportunity to bring specialty clinicians out to rural communities to provide training and clinical expertise to providers in local communities.
- Partnerships with family-based organizations (Family Voices, FACT, Oregon Family Support Network, OrPTI, Swindells Center) through the Family Involvement Network facilitate family participation in the development of program activities, as well as a forum for advocacy to illuminate the unmet need of the CYSHN population and their families.
-New alliances with Oregon Advocacy Center and Oregon Health Action Campaign as well as the Oregon Insurance Commission have resulted in better representation for the CYSHN issues at the policy level. //2007//

/2010/ OCCYSHN has made a new partner in the OHSU Department of Pediatrics through a relationship with the physician lead of the Child Health Advocacy Night, resource fair at Doernbecher Children's Hospital for child health providers and advocates. //2010//

Title V Program Cultural Competency Efforts
The Oregon Title V Program at OFH and OCCYSHN are aware of significant differences that can exist in issues of health care access and utilization across diverse communities based on geography, ethnicity, language, and socio-economic status. Activities in the Office of Family Health include analysis of program and population health data to identify disparities and engaging clients and population groups to understand the nature of those disparities. In Oregon, particular attention is focused on the Hispanic population, such as those needing family planning, preconception and perinatal care, early childhood care, and CYSHN care coordination. Efforts include creating culturally, linguistically appropriate program service models, health messages, and community engagement activities by Oregon's culturally diverse groups. OCCYSHN is exploring the National Survey of CSHCN data to determine the extent to which there are significant differences and/or trends in the results obtained from families in more urban environments versus those of rural areas.

/2009/ The Department of Human Services and the Public Health Division designed a cultural competency training curriculum that improves staff understanding and skills to approach their work, customers, and coworkers in sensitive to the origins and culture of each. //2009// A training curriculum for new local MCH leaders and staff includes a significant module on cultural and linguistic sensitivity skills. CDRC has been active with the National Center on Cultural Competency to increase the cultural competency of its staff in the provision of services to families of CYSHN. OCCYSHN partnered with the HRSA funded project on medical home with federally

qualified health centers serving children with epilepsy.

/2010/ OCCYSHN also promotes cultural competency on CCN community teams and has worked to include cultural diversity in training and hiring of Family Liaisons (current and past years). //2010//

The Oregon Title V Program allocates funds to county health departments and tribal governments using a formula weighted for those communities with higher rates of low birthweight, more women in need of contraception (family planning data), the childbearing population, and the number of persons living in rural and frontier communities. Local MCH leaders collaborate with diverse populations in their communities, such as Native Americans, Hispanics, African Americans, and both Asian and European nationals with specific cultural and linguistics needs. These populations exist in both urban and rural communities and require different approaches for each population. Minimum standards for county health departments include a requirement for culturally and linguistically appropriate services and the State PHD reviews for compliance with this standard every three years, through review of county policies and procedures.

Oregon's MCH Programs maintain resources and technical assistance for local providers to support the culturally appropriate service delivery. State regional nurse consultants are assigned areas to provide training, technical assistance, compliance reviews, and consulting on programs and services for the MCH populations. OCCYSHN conducted focus groups with Hispanic families from 3 Oregon communities about the extent to which they experienced a medical home approach to the care of their children with special health needs

C. Organizational Structure

Oregon's Title V Agency is the Office of Family Health (OFH) in the Health Services branch of the Department of Human Services (DHS). The Director of DHS is appointed by the Governor and sits on the Governor's Cabinet. DHS Health Services includes offices the Division of Medical Assistance Programs (Medicaid -Oregon Health Plan), Division of Mental Health and Addiction Services (Substance Use and Mental Health Treatment and Services), and public health offices, including Office of Disease Prevention and Epidemiology, Office of Public Health Services, Office of the Public Health Officer, Oregon Public Health Laboratory. The umbrella Health Services organization allows for "seamless" activities and partnerships around policies and issues involving the broad health system.

The Office of Family Health is located in Portland, Oregon's largest city. Important partners of the OHD in carrying out the mission of Title V are the thirty-four local health departments (LHDs) and the Child Development and Rehabilitation Center (CDRC) at OHSU. The Public Health Director is Susan Allan, MD.JD, MPH and she sits on the DHS cabinet reporting directly to the DHS Director. /2009/ Dr. Allan left her position in February, 2009. Recruitment is underway. //2009//
The Title V Director, Katherine Bradley, RN, PhD, serves as Administrator of the Office of Family Health and sits on the Executive Staff as Assistant Administrator of DHS. The OFH delivers its programs serving the MCH population through county health departments, other state and local partnerships, and in coordination with the CSHN program at the CDRC.
/2007/ The public health section has been renamed "Oregon Public Health Division," still part of DHS and more visible image to the public.//2007//
/2008/ The 2007 Legislature passed laws to establish the Public Health Director in statute and strengthen the public health capacity and authority in emergency situations. //2008//

/2010/ Dr. Melvin Kohn assumed Interim Director for the Public Health Division and State Health Officer, previously the Oregon State Epidemiologist, The Title V Director, Dr. Katherine Bradley continues as Administrator. There has been little turnover in the Office of Family Health organizational structure over the last year. //2010//

The Federal/State Partnership programs and other federal grant programs administered by the

Title V Director in the Office of Family Health:
/2008/ Organizational restructuring in the Office of Family Health will consolidate MCH programs along the lifespan range from preconception through young childhood for improved coordination and focus in program planning, development, and evaluation, policy analysis and development, epidemiology and research, consultation and technical assistance to local agencies. The MCH Section Manager, currently being recruited, will supervise Women's and Perinatal Health, Child Health, and Oral Health sections, and a newly created Epidemiology and Evaluation Section. Additionally, an MCH Emergency Preparedness coordinator is working in the Emergency Preparedness program to oversee planning and implementation for vulnerable populations. //2008//

/2009/ Below describes the current organization structure://2009//
- Women's and Reproductive Health Family Planning (Title X), Family Planning Expansion Project; women's health systems development project, rape prevention and education, sexual violence prevention state planning, fetal alcohol syndrome prevention; /2009/ Oregon Breast and Cervical Cancer Prevention Program was shifted into the Office of Family Health from the Prevention and Epidemiology office. This program is directed under the Women's and Reproductive Health Section. //2009//
- Maternal and Child Health Section: Perinatal and Early Child Health: periconception, maternity case management, Oregon MothersCare outreach, Smoke Free Mothers and Babies (/2007/ discontinued //2007//), PRAMS survey; High risk infant tracking, Early Childhood Comprehensive Systems Grant, EHDI-Early Hearing Detection and Intervention, breastfeeding promotion, Healthy Child Care America, public health nurse consultation, , FamilyNet/Orchids: Oregon CHildrens Information Data System -- client-based data system; MCH Evaluation and Epidemiology; MCH Informatics; MCH Policy Analyst
- Adolescent Health: Adolescent health promotion, School-Based Health Centers, Coordinated School Health Program, Teen Pregnancy Prevention consultation, Healthy Teen Survey, nutrition and physical activity consultation
- Genetics: public health genomics planning and implementation, family history project
- Oral Health: Oral Health Systems Improvement Project, State Oral Health Plan, Sealant Program, fluoride supplement program, early childhood cavity prevention project, Smile Survey
- WIC: Nutrition Education and Supplemental Food Program, Farmers Market, Senior Farmers Market, Breastfeeding Promotion, and demonstration projects: Peer Counseling for Breastfeeding and Five-A-Day Fruits and Vegetables promotion.
- Immunization: Immunization Program, Vaccines for Children, ALERT Immunization Registry
- MCH Systems: Title V Coordination, medical consultation, program development and planning, community health improvement projects, special projects and grant development

/2007/ No significant changes in Office of Family Health, Title V Director's Office. Womens and Reproductive Health was restructured into Reproductive Health Section and the Womens and Perinatal Health Section, with the same responsibilities as described above. //2007//

The Federal/State Partnership programs and other federal grant programs administered by the Title V Children with Special Health Needs Director in the Child Development and Rehabilitation Center:
Oregon state statute designates Oregon Health & Science the responsible agency for Children with Special Health Needs (CSHN) programs and services. Oregon Health and Science University, under Oregon statutes 444.010, 444.020 and 444.030, is the designated entity to administer the program of services for disabled children with authority to administer services for children with special health needs. The Title V CSHN services are administered through the Child Development and Rehabilitation Center (CDRC), an independent division at OHSU. Dr Nickel, the OSCSHN Director, reports to Dr Brian Rogers who is the CDRC Director. Dr. Rogers reports directly to Dr. Peter Kohler, President of OHSU, and is a member of the OHSU Executive Committee. An application to change the name of the OSCSHN office to the Oregon Center for Children and Youth with Special Health Needs has been submitted and is still pending at the office of the OHSU Provost.

/2007/ The Office of Oregon Services for Children and Youth with Special Needs was granted a name change to Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). As a long standing unit within the Child Development and Rehabilitation Center at Oregon Health & Science University, the "Center" designation clearly underscores the leadership role of OCCYSHN in addressing the needs of CYSHN in Oregon. OCCYSHN continues to be one of three main units within CDRC. The Director of OCCYSHN reports directly to the director of the CDRC and all program staff with the unit report, ultimately, to the director of OCCYSHN. OCCYSHN's functions and activities complements OHSU's mission to serve the citizens of Oregon.
In December 2005, Bob Nickel, M.D. stepped down as the director of the Oregon's Title V program for CYSHCN, but continued his role as Medical Consultant. James Ledbetter, M.D. began in January 2006 as Director. Dr. Ledbetter is a developmental pediatrician with extensive experience with the Colorado CSHCN program, acting as their Medical Consultant for the past 4 years. He brings a public health perspective to the OCCYSHN, and has worked extensively on the Medical Home and Fetal Alcohol Spectrum initiatives in Colorado. Currently, OCCYSHN employs 18 staff with 13.15 FTE. Grant and special projects provides funding for 3 staff at 1.65 FTE. //2007//
/2008/ In March 2007, Dr. James Ledbetter left the position of Director, to refocus his professional activities on health policy and health systems. Dr. Brian Rogers, Director of the CDRC, assumed the duties of Interim OCCYSHN Director. Dr. Ledbetter provides consultation to the CDRC through Dr. Rogers on issues related to health policy and children with special health needs. A search for a new Director will be initiated pending completion of a careful review of the program and its specific needs for future direction. CDRC is becoming a UCEDD as an agency, thus moving the UCEDD from a project within CDRC to applying to the entire CDRC. OCCYSHN will maintain its unique program identify, internal administrative and programmatic structure, and program budget. OCCYSHN currently employs 19 staff with 13.47 FTE. Grant and special projects provide partial funding for 10 staff at 2.42 FTE. //2008//

/2009/ On September 17, 2007 Marilyn Sue Hartzell, M.Ed. assumed the position of OCCYSHN Program Manager, assuming direct responsibility for the entire OCCYSHN program's management. In May 2008, Ms. Hartzell was appointed to Director of the Oregon Center for Children and Youth with Special Health Needs to assume those duties effective July 1, 2008; an OCCYSHN Medical Consultant will be identified.

The CDRC continues to adapt to the overarching UCEDD status of the organization. The CDRC has consolidated its efforts within the areas of public health, community outreach and policy. Charles Drum JD PhD was appointed as Assistant Director of CDRC for Public Health, Community Outreach and Policy, assuming those duties effective July 1, 2008. OCCYSHN will, organizationally, reside within this new cluster of programs. The Director of the OCCYSN will report directly to the Assistant Director of Public Health, Community Outreach and Policy. The announcement is attached. //2009//

When the Omnibus Budget Reconciliation Act of 1981 consolidated seven programs into the Maternal and Child Health Block Grant, the governor of Oregon designated the Oregon Health Division (OHD) (currently Office of Family Health) as the recipient of the Block Grant funds. OHD has contracted with CDRC for SCSHN since that time. In 1989, as a result of the OBRA 89 Amendments to the MCH Block Grant, states were required to use at least 30% of the funds on SCSHN, with not more than 10% on administrative costs. At that time, the mission of the state CSHCN program was revised to include a focus on the development of community-based systems of care for these children and their families that promote family-centered, community-based, coordinated care. /2009/ CDRC and OFH will be renegotiating their 5 year Inter-Agency Agreement prior to September 2008. // 2009//

The CDRC is a statewide service program that provides health and rehabilitative care for children with special health needs and their families and includes a tertiary clinical program, the Title V

Oregon Services for Children with Special Health Needs (OSCSHN), and the Oregon Institute on Disability and Development. The CDRC has offices in Portland and Eugene. A variety of tertiary care clinics are offered at both the Portland and Eugene offices. These clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the University Affiliated Program at the University of Oregon. The CDRC also administers two community-based programs for CSHN through the OCCYSHN. The first, the CaCoon (CAre COordinatiON) is an exemplary statewide care coordination program that provides public health nursing services in communities where families live. The second, Community Connections Network (CCN) coordinates community clinics in fourteen sites.

/2010/ Financial constraints of 2009 will result in a reduction of support to the CCN resulting in an anticipated reduction in number of CCN Teams from fourteen to nine around the state.//2010//

/2010/ The Office of Family Health and the OCCYSN completed a new 5-year contract to continue relationship for the Title V Children with Special Health Needs programs to be administered by OHSU. The Title V office in the Public Health Division transfers thirty percent of the total annual Title V awards. //2010//

Attached are organizational charts for Office of Family Health, Oregon Center for Children and Youth with Special Health Needs, and the relationship of both to the Governor.

An attachment is included in this section.

D. Other MCH Capacity

The Office of Family Health employs approximately190 permanent and temporary staff, with expertise and skills in all program areas. The direct delivery of MCH programs is provided by staff at local health departments, funded by Title V and other federal and state funds through grants to counties. There are approximately 2,000 county public health staff persons in Oregon, not including staff at non-profit or tribal health centers. This includes 34 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professional staff in Oregon LHDs. The Office coordinates the OFH local Agency Review process on a three-year on-site cycle to provide consultation for local public health services.

The Oregon Children and Youth with Special Needs staff have expertise in public health nursing, special education, community engagement and development, evaluation and research, family involvement and family professional partnerships and rehabilitation services. The Center is comprised of 4 core program activities: the Community Connections Network (CCN), the CaCoon Program, the Family Support Program (FSP) and the Family Involvement Network (FIN). OCCYSHN maintains an ongoing relationship with the Office of Program Evaluation and Research within CDRC from which it receives its evaluation and research services. OCCYSHN has a half-time Evaluation Specialist on staff, a new position to the OCCYSHN program. At present, 18 staff (13.31 FTE) work in the OCCYSHN Title V office at CDRC. /2007/ The Medical Home Project is no longer funded and Learning Collaborative on Adolescent Transition has been completed with the project staff working on dissemination findings and ‘spread'. //2007//

/2008/ The Adolescent Transition Learning Collaborative was completed in the 6 participating counties. Lessons learned, tools and best practices were gleaned from each site and shared with other counties and programs in an effort to "spread" the information, including the sharing of a web page with additional information. The Youth Advisory group established as part of the AT Learning Collaborative continued to meet, developing leadership skills of youth with disabilities. //2008//

/2009/ OCCYSHN employs 19 part and full time staff in 4 core program activities. //2009//

/2010/ OCCYSHN has added to its core staffing pattern an Evaluation and Research Consultant 0.50fte effective January 2009. Lisa Lyman, Ph.D., provides consultation and coordination for OCCYSHN's evaluation and research activities. Dr. Lyman is a health services researcher whose specialties include access and quality of pediatric care, community-based systems of care for CSHCN, and epidemiologic analysis of secondary data.

Effective July 1, 2009 OCCYSHN's staffing pattern will change significantly. OCCYHN will incur a reduction of 3.70 FTE of its current staff and then add staff who are being reassigned to the Title V program through the partnership to integrate clinical and public health activities. The new Title V-sponsored integrated clinical and public health program component will result in an additional 5.08FTE increasing the Title V CYSHN program capacity in the areas of behavioral health, care coordination, medical consultation with an emphasis on autism spectrum disorders, genetics and high risk infant care and care coordination. OCCYSHN's total Title V supported program staff will be 13.35FTE over 24 professional and support staff. New capacity of the OCCYSHN program includes expertise in behavioral health, developmental pediatrics with a specialty in autism and the provision of medical consultation, genetics, high risk infants and expanded care coordination capabilities.//2010//

The Oregon Title V Director is Katherine Bradley, RN, PhD and the Oregon CYSHN Title V Director is James Ledbetter, MD. The directors each have over 20 years experience directly serving women and children and participating in local, state and federal level policy and program development and decision making. /2008/ Dr. Brian Rogers, CDRC Director, has assumed the role of Interim Director for OCCYSHN until a replacement can be identified. Dr. Rogers bring 30 years of experience in the field of CYSHN. //2008//
/2009/ Dr. Ledbetter left his position Winter 2007. After remaining open for a year, the position was filled by appointment of Marilyn Sue Hartzell, M.Ed., previously OCCYSHN Program Manager. Ms. Hartzell assumes her duties as Director effective July 1, 2008.//2009//

In the Office of Family Health, each section is staffed with many years experience in public health program planning, implementation, and evaluation, and includes research analysts to evaluate data from a variety of data sources; most staff has graduate or doctoral level degrees. Professional consultants, section managers, and administration positions report to the Title V Director. Consultants include the MCH Medical Epidemiologist, Medical Family Practice Consultant, Early Childhood Mental Health Consultant, MCH Informatics, and MCH Program Specialist. The Child Injury Prevention Coordinator is supported with Title V funds and is located in the Injury Prevention Program, in the Office of Disease Prevention and Epidemiology, within the Public Health Division. The Injury Prevention Program also conducts research and surveillance of intimate partner violence, working in partnership with the OFH Women's Health Program.

Local Title V Programs are delivered though county health departments through intergovernmental contracts. Counties develop annual program plans for MCH, Family Planning, Immunization and WIC. Program policies and resource issues are negotiated through the Conference of Local Health Officials, and the MCH Committee. Other advisory groups partnering with OFH programs to develop policies and programs include: State Early Childhood Team, Oral Health Advisory Committee, WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Prevention Task Force, FamilyNet Advisory Committee.

All 36 counties have an Early Childhood Team to facilitate or conduct screenings of health and psycho-social risk in prenatal and postnatal health care settings; establish partnerships with the medical, public health, and social services community; and develop a process for connecting families to information, assessment, and services in the community. The OFH and the CDRC are primary partners in implementing the plan by providing expertise in nurse home visitation and

data collection systems.

The CDRC employs people with disabilities and parents of CYSHN in a variety of roles. Parents of CYSHN are employed in project management, as family consultants, in grant planning and evaluation, administration of family support programs and gift funds and as consultants to grants, other projects and training initiatives. Through the Family Involvement Network (FIN), three family members hold part time positions specifically to assist the program with broad parent perspectives, to enhance connections throughout the state with parents of CYSHN, and to assist and arrange for training opportunities for both families and professionals. One of these parents is the first parent to participate in leadership training through the LEND program of the OIDD. The state Family Voices coordinator is the parent coordinator of FIN. Community-based liaisons and teams, and the Multicultural Task Force, CDRC continues to make family professional partnerships and participatory action initiatives a high priority. /2008/ The OCYSHN parent consultant provides input to OFH (non-CYSHN) programs when needed. Plans to add a family consultant as part of OFH staff is identified in OFH capacity building plans. //2008//

/2007/ OCCYSHN was awarded a HRSA integrated services grant titled "SOCs: Strengthening Oregon Communities" making in possible to integrate the initiatives associated with the CSHN performance measures into the programs that are supported at the community level. Dr. Ledbetter assumed the role of Principle Investigator for the SOCs grant. Although addressing all six Title V National Performance Measures for CSHCN, this grant allows OCCYSHN to concentrate efforts on health insurance coverage for CYSHN, increased family participation in quality improvement planning at the medical practice level, continue our work in the area of Adolescent Transition, and improve developmental and behavior screening for children 0-5 years. The identification of local, culturally appropriate resources will be an effort to support the web-based Disability Compass Resource Guide. //2007//

/2008/ OCCYSHN served as a placement for a LEND trainee who was linked to experiences in the CDRC clinics and the resulting referral and follow-up to community based services. The LEND trainee studied referral practices and made recommendations for strengthening this linkage from clinic to community. A LEND psychology intern was supported to complete her LEND community rotation with OCCYSHN. She reviewed community mental and behavior health services available for children 0-8 years. Her work will be used to inform planning processes for improvement in meeting the behavior and mental health needs of CYSHN. //2008//

/2010/ The SOCs grant is completed. This will be the first program year within the past 10 years that OCCYSHN will not have available grant dollars from the integrated systems grants. Aggressive grant seeking and writing is underway to increase program capacity in furtherance of its state systems development, policy development, training and community-based activities. //2010//

MCH EPIDEMIOLOGY CAPACITY:
The Office of Family Health has a maternal and child health epidemiology program that conducts surveillance of the population for use by OFH and other state and local organizations. Dr. Ken Rosenberg provides consultation and surveillance of MCH population health status to OFH programs and other local and state organizations. Dr. Rosenberg has been the Project Director of Oregon PRAMS (Pregnancy Risk Assessment Monitoring System) since 1998. Dr. James Gaudino provides consultation and surveillance of immunization in Oregon and consultation with Title V issues and activities as well. /2008/ Elizabeth Adams, PhD is the MCH Epidemiologist for the CSHN population, providing consultation and analysis to the CSHN Title V program, and oversees special studies, conducted by the GSIP Intern and a LEND epidemiology trainee. The GSIP Intern used current population survey data to assess the prevalence of disability at the county level among children 5-15 years of age. Dr. Adams consults on measurement and monitoring activities using data sources such as NSCYSHCN and Oregon PRAMS 2. A Pediatrician-MPH student conducted an analysis of the CaCoon program in preparation for a

focused program evaluation. OCCYSHN re-visited its work in the area of measuring and monitoring Oregon's progress toward achieving the National Performance Measures. A workgroup is comprised of key leaders within the OCCYSHN program, its evaluator and CAHMI as consultants. The project will identify data sources to support a more thorough examination of the status of Oregon's children relative to the performance measures, as well as identify special studies to pursue around those data sources. //2008//
/2009/ Dr.Liz Adams has been appointed Director of the Office of Program Evaluation and Research. She is the lead contact with the OCCYSHN program to provide ongoing program evaluation and epidemiological study consultation and studies. OPER has expanded its capabilities with the addition of a health services researcher. //2009//
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/2008/ Dr. Laurin Kasehegan, CDC Fellow, completed the following projects during 2006-07: Conduct evaluation of state PRAMS questions; consulted with EHDI program coordinator to rewrite analytic code and analyze data for annual progress report;
consulted on ORCHIDS client database development with regional nurse consultants and software developers to develop and design data collection instruments for Oregon MothersCare, Oregon Maternity Case Management, Oregon Babies First! and Oregon CaCoon programs; served as FAS epidemiologist for start up of surveillance system and conduct of FAS surveillance; team member for development of the Perinatal Data Book. //2008//

/2010/ ORCHIDS is now able to capture key performance and outcome measures for MCH home visiting and OCCYSHN programs statewide. All ORCHIDS data goes into the data warehouse for the purpose of reporting and analysis, and was used for testimony and information in the 2009 Legislative Session. Work is underway to address additional reporting needs for local health department staff and to import ORCHIDS data electronically from the Electronic Health Record (EHR) used by Multnomah County (Oregon's largest metropolitan county) because Multnomah County does not use the ORCHIDS interface to capture the data. Once that data import is implemented, all Oregon counties will be included in the ORCHIDS data warehouse. //2010//

/2009/ The new MCH Evaluation and Epidemiology Unit is now staffed and will provide supervisory and organizational development management to increase and improve the ability to provide program evaluation for quality improvement and more effective policy development. The Unit will be recruiting for a doctoral-level or equivalent program evaluator to provide technical expertise across OFH programs. //2009//

/2010/ The Title V Program now includes Program Evaluation professionals in addition to additional capacity in data analysis and epidemiology. This includes a PhD level program evaluator and a CDC/CSTE Applied Epidemiology Fellow until 2012. The added capacity will greatly improve the ability to conduct ongoing needs assessment and evaluation to better plan programs and policies. //2010//

Oregon PRAMS, which joined the CDC PRAMS system in 2002, has enhanced the ability to identify problems, and develop and track health status indicators and performance measures. Survey results are posted on the OFH web site http://www.dhs.state.or.us/publichealth/pch/prams/index.cfm. Dr. Rosenberg is leading a wide collaborative development turning PRAMS from a cross-sectional survey to a longitudinal survey. The "PRAMS-2" survey -- The Oregon Two-year-old Survey - will re-interview PRAMS respondents when their babies are 2 years old. The survey will begin in the fall of 2005. Among the topics will be well child care, chronic disease, immunization, breastfeeding, nutrition, physical activity, development, domestic violence, stress and social support, and tobacco and alcohol use. More information about PRAMS-2 can be found in III.F. Health System Capacity Indicator 09A.

/2007/ The PRAMS 2 survey for health of two year olds mothers who responded to the PRAMS surveys began implementation in 2005-06. First results should be available in 2007. //2007//
/2009/ Data from the first PRAMS-2, collected 2006 for 2004 births, has been weighted and is

ready for analysis. Several programs have access to the data set for analysis. //2009//

/2008/ OCCYSHN played a substantial role in designing a question included in the Oregon Healthy Teens Survey (the Oregon Youth Risk Behavior Survey). These data provide greater understanding Oregon youth with special health needs and the healthy behaviors that they engage in compared to teens who do not report having a special health needs. These questions began with the 2006 survey. //2008//

/2010/ OCCYSHN has financially supported the inclusion of four items within the Oregon PRAMS-2 Survey. Data are currently undergoing analysis and preparation for dissemination. OCCYSHN is considering replacing currently supported items with the CSHCN Screener in order to allow for a standardized and validated method for surveillance. Adoption of the CSHCN Screener is contingent upon fiscal feasibility.//2010//

The Office of Family Health actively planned and participated in the 3rd Western MCH Epidemiology Conference was held in May 2005 with participation of 15 western states. Conference was attended by about 200 people, mostly tribal, state and local health department staff. Plenary presentations were on Health Disparities, Fetal Alcohol. /2008/ Attempts to raise resources for subsequent MCH Epidemiology Conferences have been unsuccessful since 2005. /2008/ Funding resources for a western states MCH Epidemiology Conference were unavailable in 2006 and 2007. //2008//

/2009/ OFH has presented methodology using PRAMS data to understand the magnitude of the problem of perinatal depression in Oregon and identify which women were at highest risk for perinatal depression. The outcome will be a report on Perinatal Depression in Oregon and will be used to develop a comprehensive approach to increase identification and treatment of depression through partnership development, provider education, screening and referral, enhanced infrastructure and services, and research. //2009//

E. State Agency Coordination

State Title V Programs in OCCYSHN and OFH value the collaboration and coordination among partners, stakeholders, and between their respective programs. Family participation is highly valued and family liaisons are included in policy and program development and evaluation activities. With the Title V programs in two different agencies, the effort to coordinate and cross-communicate regarding common stakeholders and partners and common endeavors is a high priority in order to create a kind of seamless representation of Oregon's Title V programs whenever appropriate.

The Office of Family Health extensively facilitates and promotes collaboration and coordination among state, local and non-profit agencies as ongoing development and maintenance of a system of care for the maternal and child health population. State level relationships among core health system agencies increase the ability of Title V to build collaborations and coordination around activities and programs addressing the health needs by population group.

The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) resides within the Child Development and Rehabilitation Center (CDRC) of the Oregon Health and Science University (OHSU). The Director of CDRC reports directly to the Vice-Provost of OHSU. The CDRC co-houses with the Department of Pediatrics and is beginning to integrate clinical operations to increase efficiencies.

/2010/ Changes in agency coordination and partnerships was minimal. Efforts were spent planning needs and opportunities for improvement of partnerships that will assist the Title V programs in achieving its goals. New collaborations and partnerships are building

include those with private providers, particularly the Oregon Pediatric Society, early childhood interests, academic and providers for women's health and maternal depression, and community-based partners. //2010//

1) EPSDT:

EPSDT in Oregon is administered and implemented through DMAP (Medicaid agency) and its contractual arrangements with managed care and other providers. Title V and its public health programs as well as the Early Intervention/Early Childhood Education programs of the Oregon Department of Education coordinate with DMAP and health care providers, especially in relation to early screening, care coordination and some therapies. OFH and OCCYSHN with DMAP and OPS partners have facilitated statewide efforts to increase the practice of developmental screening and to improve reimbursement processes for OHP providers. Emphasis on early screening and referral to appropriate follow up services is included in care coordination and home visiting programs (Babies First! And CaCoon). These programs are implemented through local health departments and are coordinated with community providers of services to young children. OFH is facilitating development and implementation of Oregon's Early Childhood Comprehensive Systems Plan and has engaged a large number of partners in the process (.http://www.oregon.gov/DHS/ph/ofhs/mch/docs/eccsplanexcsummary.pdf). Components of the plan include access to health care, screening, and follow up care as part of efforts to assure that Oregon's children are healthy,safe and ready to learn. /2009/ Oregon's ABCD Early Childhood Screening Initiative made significant progress in the last year to clarify EPSDT program. The ABCD Initiative raised awareness about the CPT code 96110 for limited developmental screening and paired it with well child visits. Additionally, the ABCD clinician group has created recommendations for standardized screening tools, that are included in the Oregon Health Plan guidelines for preventive care. The ABCD project is working with the EI/ECSE office to create referral forms and methods that will increase communication between EI and providers, as a component of improving early childhood screening and referral. //2009//

Public Screening Programs:
Babies First! High-risk infant tracking is a nurse home visiting program, administered by Office of Family Health that tracks the needs for infants and families with multiple risk factors, including developmental delays. The Oregon Care Coordination Program (CaCOON) provides a public health nurse presence on each LICC in every local county to represent the needs of CYSHN in early childhood services. It has contributed to the development of the statewide reporting system and supports its implementation through ongoing technical assistance to the local program. These Title V programs include joint training and coordination with county public health nursing staff.

Healthy Start, administered by Oregon Commission on Children and Families (OCCF) provides screening and referral for all first births in Oregon, with paraprofessional home visitors. The CDRC works with the Commission at the state and local levels to avoid duplication and to train the participants in home visiting programs. At the community level, these programs collaborate in unique ways to serve their communities, such as hiring a Healthy Start worker as a Promotora to provide services to the Latino community, and works with the CaCOON Nurse.
/2009/ Oregon is currently implementing a continuum of home visitation programs using Federal, State, local and private funding streams. Oregon's home visitation continuum includes a state infrastructure and a combination of proven and unproven models. Oregon's Public Health System has long recognized the importance of delivering proven home visiting models within a continuum that assures safety net services for families not eligible for proven evidence based models. //2009//

Other screening programs include:
- Early Hearing Diagnosis and Intervention Program (EHDI) is established in the OFH and reports directly to the Title V Director. A multi-disciplinary advisory committee provides direction for the

entire newborn hearing screening process in which both the OFH and OCCYSHN participate. EHDI and the CDRC collaborate to assure appropriate follow up for children with potential hearing loss.
- Metabolic Screening is administered by the Public Health Laboratory provides newborn metabolic screening to all Oregon infants. Newborn screening follow-up, program consultation, quality assurance and education are provided by the CDRC. Through this agreement, all infants suspected of having metabolic problems are referred to the CDRC for follow-up.
- Office of Family Health, CDRC Special Education, Education Service District and OCCYSHN partnered to develop a matrix of developmental screening tools for use by public health nurses and community providers, began discussion of reciprocity of test findings and established protocol for referral feedback between provider and Early Intervention.
/2007/ OCCYSHN initiated exploration of a Universal Application System, "Oregon Clicks" which included extensive coordination and collaboration to develop and pilot with the Babies First! Program, the Division of Medical Assistance Program (DMAP), and ODE/ Early Intervention a web-based integrated application. Utah State University Champions for Progress staff provided technical assistance to the project. //2007//

2) Other federal grant programs -- WIC, developmental disability, family planning:
Immunization: The Immunization Program, funded primarily by CDC, works closely with the Local Health Departments and the Department of Education and the Employment Department to monitor and enforce school entry requirements for day care facilities and schools. The Oregon Partnership to Immunize Children (OPIC) and the Oregon Adult Immunization Coalition (OAIC) are private and public sector partnerships committed to improving immunization coverage rates in their respective populations. /2008/ DMAP is providing immunization assessment data and quality improvement strategies for Oregon Health Plan managed care plans. A new joint committee of OPIC and the Immunization Policy Advisory Team (IPAT) is working together to develop vaccine financing solutions to assured vaccines remain affordable. //2008//

Adolescent Health: The Coordinated School Health Program, a state-level partnership with the Oregon Department of Education, has continued to support development of the Healthy Kids Learn Better Coalition, which now represents over 40 statewide organizational-level partners to promote public policy and legislative agendas that support coordinated school health concepts and focal areas. /2008/ Adolescent Health participated in the DHS Mental Health-Primary Care Integration project and the Steering Committee for the EAST (Early Assessment & Support Team) Early Psychosis Screening Project with the Mid-Valley Behavioral Care Network. This project was the result of receiving a $2 million Robert Wood Johnson Foundation grant to reduce the incidence of psychotic illness by intervening with youth showing early signs of psychosis. //2008//
Healthy Kids Learn Better (Coordinated School Health) Program: A key state-level partnership with the Oregon Department of Education that supports implementation of the coordinated school health systemic change model and framework at the local school level to address health-related barriers (e.g. nutrition, physical activity, tobacco) to learning and educational success. :
/2007/ In 2006, 13 new sites are planned, 5 of which who will focus on tobacco, physical activity & nutrition, 4 on asthma. A new HRSA funded initiative was added to allow schools to apply for funding to focus on mental health issues in their school using the Coordinated School Health model and will add 4 additional projects. //2007//

Genetics: The Genetics Program collaborates with La Clinica del Cariño Family Health Care in Hood River, Oregon, to determine if the current methods of collecting family history information accurately and completely capture this information and with Kaiser Permanente on an assessment of family history tools. Information gleaned from these studies can be used to develop future prevention and intervention programs related to use of family history in the clinical setting.
---Title V programs collaborate and coordinate with CDC funded programs centered in the Office of Disease Prevention and Epidemiology for chronic disease prevention, particularly in implementing the State Plan on Nutrition and Physical Activity, Diabetes, Asthma, and Breast and

Cervical Cancer. /2009/ Breast and Cervical Cancer program is now located in the Women's and Reproductive Health Section in the Office of Family Health (Title V). //2009//
- Title V programs collaborate and coordinate with SAMSHA funded programs located in the Division of Mental Health and Addiction Services. These OFH programs include the Mental Health Initiative in the Healthy Kids Learn Better Program (coordinated school health), Early Childhood Comprehensive Services, and FAS Prevention.
- WIC and Immunization have joined in a coordinated effort to refer WIC and perinatal clients to appropriate immunization services for mothers, infants and preschool children.
- The Breastfeeding Initiative is a program coordinated between WIC and Child Health nutritionists to improve the nutritional and healthy status of infants.
- Oregon's MothersCare is an initiative tostreamline, coordinate and promote access to early prenatal care through coordination of referral systems and linking women to the state toll-free hotline (SafeNet), pregnancy test sites, local health departments, OHP (Medicaid), Maternity Case Management, WIC and other agencies that provide prenatal services.
/2007/ The Oregon Title V Program collaborated with Oregon HRSA programs to participate in the HRSA State Strategic Partnership Review for Region X. The programs include: Office of Primary Care, Oregon Primary Care Association, Oregon Office of Rural Health, and the Ryan White Title II Program. The Strategic Partnership identified a common priority around "access to health care" and is investigating common performance measures appropriate across all programs. A joint planning meeting will occur in late 2006 with the five agencies and their key partners to develop strategies and outcomes around the priority goal. //2007//
/2008/ The joint meeting occurred in November 2006, and the final outcome recognized access to care as an overriding challenge. Interventions and activities targeted to each population are different enough to narrow the scope into a feasible and effective effort. The programs benefited from the discussions, enhancing future collaborations. //2008//
- The Title V and Title XIX agencies, with other private and public providers, participate on joint committees to facilitate the coordination of services with common clients, including a DHS-wide Medicaid Advisory Committee

WIC: WIC actively participates with the Oregon Hunger Relief Task Force in the created by the 1989 State Legislature to act as a resource within government and as a statewide advocate for hunger issues. WIC also partners with the Farm Direct Nutrition Program, Oregon Dept. of Agriculture, Oregon Seniors and People with Disabilities, Oregon Farmers' Market Association, and Oregon Food Bank to provide fresh fruits and vegetables from farmers' markets and farm stand to eligible senior citizens and individuals eligible for WIC. ***/2010/ The new "Fresh Choices" vouchers increasing fruits and vegetables provides increased opportunities to partner with grocers and farmers markets. //2010//***

3) Providers of services to identify pregnant women and infants eligible for Medicaid and assist in applying for services
Early Child System of Services and Support: OFH and OCCYSHN staff participate with the Governor's Interagency Coordinating Team to implement an Early Childhood System of Services and Support in Oregon. /2008/ OFH and OCCYSHN staff participate on the Early Childhood Team, an interagency coalition of early childhood service agencies, on the development and dissemination of the comprehensive Early Childhood System Plan. Family consultants from OCCYSHN staff assisted the Early Childhood Team in developing a job description and guidelines for parent participation on the team. //2008// /2009/ Early Childhood Team renamed to Early Childhood Council in response to the Governor's Summit on Early Childhood in March 2008. //2009// ***/2010/ Early Childhood Matters is a framework for a public-private partnership to share information and coordinate efforts by a variety of agencies and other partnerships. //2010//***
FamilyNet Data Integration: Agencies involved in development are Oregon Commission for Children and Families, Oregon Dept. of Education, OCCYSHN, Conference of Local Health Officials, county health departments, Oregon Healthy Start, public health offices of Public Health Laboratories (OSPHL) and Disease Prevention and Epidemiology (ODPE), and Early Intervention agencies. /2008/ The ORCHIDS data system (client master of FamilyNet) will be rolled out in

counties beginning August 2007. //2008// /2009/ ORCHIDS fully rolled out in every county as of June, 2008. //2009//

Managed Care Organizations and Health Plans: Representatives of OHP managed care health plans participate in a number of advisory groups such as the group that developed practice-level definitions of CYSHN and the Medical Home advisory group. Title V staff and OCCYSHN staff have presented to the medical directors group OHP managed care organizations and begun to meet with the medical directors and care management staff of ODS, Care Oregon, Regence Blue Cross and Providence health plans to share information about community services and to collaborate on educational programs for providers and families. The SOCS grant will continue to support these activities. /2007/ OCCYSHN partnered with health care advocacy groups and health plans about health care financing in Oregon and provided a forum with Title V OFH participating to discuss next steps to benefits counseling and managed advocacy for families and children with special needs. //2007//
Children, Adult and Families Services Division (CAFD): Community-Based Application Assistance project (to expand access to OHP and early prenatal care), Students Today Aren't Ready for Sex (STARS) Abstinence Program, Teen Pregnancy Prevention; Early childhood
Division of Medical Assistance Programs: Lead Screening, Community-Based Application Assistance Project, Dental Health Services, Preschool and Adolescent Immunization, Vaccine for Children, Family Planning Expansion Project, School-Based Health Centers, VISTA Health Links, Oregon MothersCare, Maternity Case Management, Babies First! CaCoon; Childhood Cavity Prevention, definition of CSCHN, early child mental health; /2008/ ABCD Learning Academy technical assistance grant is a partnership between Title V, DMAP, and the Oregon Pediatric Society. //2008// ***/2010/ The Title V Program is working extensively with DMAP to implement the Assuring Better Child Health and Development (ABCD) program to change practices and reimbursement for developmental screening. //2010//***

Partners for Children and Families: The PCF is a collaboration of social services, education, child care, public health, juvenile justice, and citizens. Early Childhood Comprehensive Systems Initiative (HRSA-CISS-SECCS grant) works extensively with this organization in developing its plan.
Division of Mental Health and Addiction Services: The Oregon Teen Health Survey is Oregon's Youth Risk Behavior Survey, and is implemented as a partnership between the Title V Adolescent Health Program and DMHAS. DMHAS and Title V collaborate on issues and workgroups around perinatal, early childhood and adolescent health, including the fetal alcohol syndrome prevention.
- The OFH has agreements with a variety of schools to provide a school fluoride rinse program. This includes the provision of fluoride supplies to schools and training programs for teachers, professionals, and volunteers.
- The Immunization Program contracts with DMAP to improve age-appropriate rates among Medicaid children to 90% by two years of age and implement a plan to promote adolescent immunizations. The Immunization Program also contracts to purchase vaccine to provide vaccines under the Title XXI, Children's Health Insurance Program.

4) Coordination with SSA, SDDS, VocRehab, and family leadership and support programs
County health departments, school districts, Educational Service Districts, hospitals or public health departments
CSHN Definitions: /2007/ OCCYSHN and the Office of Family Health are collaborating to develop a common definition for CSHN in Oregon, with DMAP, Regence BlueCross/ BlueShield, Kaiser Permanente and other health care plans, Providence Child Center, Oregon Department of Education, Oregon Commission of Children and Families, and parents. The workgroup developed and recommended two approaches and associated sets of tools to define CSHN. A validated list of diagnostic codes is recommended as a common method for identifying CSHN at the systems level and screening and complexity level tools are recommended for use at the practice level. //2007//
/2009/ OCCYSHN plans to review and update these recommendations for currency. //2009//
- OCCYSHN and the Division of Medical Assistance (DMAP) have an interagency agreement to

address reimbursement rates for services provided at tertiary clinics. DMAP Medical Director and staff participate on CDRC/OCCYSHN committees such as the Stakeholders group, on financing health care for CYSHN, the technical assistance provided to the OCCYSHN office and other agencies on the Universal Application System, and the COIT (Child Development and Rehabilitation Center and the Oregon Department of Education Interagency Team) on Child Find.
Oregon Department of Education (ODE): Both OFH and OCCYSHNS work together on issues that cross health and education include early intervention and Child Find, early Head Start, coordinated school health, adolescent transition, early referral from NICUs to community-based programs, , and personnel preparation. For example, staff from the OCCYSHN office, the OFH and ODE are working together to revise the established risk criteria for EI/ECSE, consider provisional risk criteria for eligibility and to agree on common developmental screening tools. CDRC and the ODE update the interagency agreement on a yearly basis.
/2008/ - OFH staff and OCCYSHN staff participate on the State Interagency Coordinating Council and OCCYSHN co-leads the CDRC-ODE Child Find subcommittee. Joint efforts with the Oregon Department of Education include revising established and probable risk categories for EI, reviewing screening tests/protocols, and exploring use of a standard "universal referral form" for EI that includes feedback to referring providers.//2008//
/2009/ ABCD Screening Initiative is facilitating further development of the COIT referral/feedback tool for referring providers. ODE is a collaborative partner in this process. //2009//
- Oregon Pediatric Society (OPS): Title V staff collaborate with OPS on a variety of issues. The OCCYSHN Medical Director, Dr. Nickel, is chair of the OPS Committee on Children with Disabilities (CCWD). This partnership has resulted in joint support of learning collaboratives on preventive care, chronic conditions, and other activities to support medical home improvement. The OPS and CDRC co-sponsored a survey of Oregon's pediatricians and health plans on coding and reimbursement. /2009/ Oregon's ABCD Screening Initiative has furthered the strength of partnerships between Public Health, CYSHN, and private provider services. //2009//
/2007/ Dr. Ledbetter, OPS Executive Member and Director of the OCCYSHN office, represents CDRC on the State Interagency Coordinating Council for Early Intervention/Early Childhood Special Education. CaCoon Nurses participate on the Local Interagency Coordinating Councils. //2007// /2009/ Marilyn Hartzell, recently appointed as Director of OCCYSHN has assumed the representing role of OCCYSHN on the SICC and will identify a Medical Consultant who will also join the SICC.//2009//
The Oregon Rural-based Practice Research Network (ORPRN) and the Office of Rural Health (ORH) at OHSU. OCCYSHN maintains collaborative relationships with ORPRN and ORH for activities in the SOCS grant. Twenty-eight primary care practices participate in ORPRN including 2 pediatric practices. Pediatricians in these 2 practices also participate in the CCN. The ORH staff conduct community planning and OCCYSHN has provided information to use with a number of community planning groups in rural Oregon.. The OCCYSHN office will work with 3 of these groups to establish the Health Watch committees of the SOCS grant. /2009/ The Health Watch Committee approach did not develop as anticipated. Efforts to address health care finance turned toward legislative education and updates.//2009//
Oregon Mental Health and Developmental Disabilities (MHDD): An MHDD staff member participates on the interagency team addressing adolescent transitioning, and the manager of the Family Support Program of the OCCYSHN office was appointed by the Governor to serve on the Oregon Council on Developmental Disabilities. In addition, a MHDD staff member who is also a parent of a CSHN is a member of the OCCYSHN Family Support Program advisory committee.
Vocational Rehabilitation Division (VRD) and the Social Security Administration (SSA): The CDRC, SSA and the Disability Determination Services (DDS) of VRD educate providers about Childhood SSI eligibility, outreach to potentially eligible families, and ensure that families who apply for SSI receive information about available services. Representatives of VRD are participating on the 6 community teams of the youth transition learning collaborative. Staffs from both VRD and SSA have participated in previous Title V sponsored conferences.
Shriners Hospital for Children: The CDRC and Shriners Hospital collaborate on adolescent health transitioning and medical home issues and CDRC pediatricians regularly staff clinics at the Shriners Hospital. Shriners' care coordinators have participated in Title V OCCYSHN sponsored conferences, and the Title V OCCYSHN nurse liaison meets regularly with the care coordinators

at Shriners Hospital to discuss ways to facilitate referrals to local public health nurses. OCCYSHN and Shriner Hospital co-hosted an interactive videoconference on Obesity Prevention and Treatment for Children with Special Needs.
- Hospital NICUs and Pediatric ICUs: Staff from the OCCYSHN office work with hospitals throughout the state to educate case managers, discharge coordinators and social workers about community-based programs for CSHN. A brochure for parents of premature infants about community resources was developed, personalized by each hospital's NICU staff and distributed to families. In addition, a CD of county resources, in particular the CaCoon and CCN programs, was provided to hospital discharge coordinators.
- Family Organizations: The OCCYSHN supports the planning efforts to obtain and implement a parent-to-parent network for families with CYSHN. OCCYSHN family staff participate on various local task forces and committees such as Arc, United Cerebral Palsy (UCP), early intervention councils, community service clubs, and neighborhood meetings. Oregon Family Voices worked with the OCCYSHN Family Involvement Network in collaboration with the Oregon Parent Training and Information Center, the Family Action Coalition Team and other family organizations to submit a CMS grant for a family resource center.

/2009/ OCCYSHN Family Consultants continue to collaborate with additional groups, including Precious Beginnings, the IEP Partners project and the Oregon Family Support Network for families with children with mental health disorders. One of the parents in FIN program is a member of the OFSN.//2009//
- Oregon Regional Hemophilia Center: The Oregon Regional Hemophilia Treatment Center based at the CDRC has been the designated federal regional care center in Region X since 1976. Subcontractors are in each of the four Region X states and a satellite hemophilia program is in Spokane. Team members visit work sites, physicians' offices, emergency rooms, and local health departments.
- Providence Child Center (PCC) and the Swindells Family Resource Center: OCCYSHN staff including members of FIN meet regularly with Swindells' staff. Providence representatives were invited to the Universal Application System an activity of the SOCS grant, Health Care Finance initiative, and a stakeholders meeting to improve collaboration of agencies that maintain resource guides.
- Child Care and Respite Care: A representative from OCCYSHN has participated in the development of the Multnomah County Lifespan Respite Network and currently sits on the Inclusive Child Care committee of the Oregon Council on Developmental Disabilities. This project currently conducts 12 pilot projects to assist the families of CYSHN to locate appropriate child care and respite resources and provides funds to supplement child care costs.
Western States Genetic Services Collaborative (WSGSC): the Oregon WSGSC staff is collaborating to pilot a practice model to deliver genetic services to families living outside the Portland metro area. The partnership includes OCCYSHN staff, CDRC genetics and metabolic clinic staff, county public health nurses, and community hospitals. The WSGSC is working to determine how to provide genetic counseling for the parents of all infants with metabolic conditions, hemoglobinopathies, and CAH detected by newborn screening, in partnership with OPHL newborn screening program and public health nurses. The DMAP is working with the WSGSC to develop a method to make wise decisions about the genetic services to be paid by the Oregon Health Plan. //2007//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	18.1	15.1	14.8	14.1	14.1
Numerator	414	346	342	328	328
Denominator	228294	229032	230908	232408	232408
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source:
Numerator: Hospital Discharge Data, 2007.
Denominator: Portland State Population Research Center, 2007 data.

Notes - 2007
Source:
Numerator: Hospital Discharge Data, 2007.
Denominator: Portland State Population Research Center, 2007 data.

Notes - 2006
Source: Hospital Discharge Data

Narrative:
ICD-9 codes for hospital discharge data are readily available for the numerator and denominator to Oregon's MCH program. The program links with early childhood health programs in Office of Family Health such as Child Care Health Consultation and High Risk Infant Tracking home visiting program.
/2009/ Hospitalizations for asthma in Oregon children less than five has steadily decreased. A report on Oregon children with asthma on Medicaid in 2004 2005 showed that for every 100 children under five with asthma who were on Medicaid, there was an average of over 6 hospitalizations for asthma a year. The highest rates for hospitalization in this report were in mostly rural counties. Some factors that may influence asthma hospitalizations in children include environmental conditions (both indoor and outdoor), parent's ability to read and comprehend health information, secondhand smoke exposure, cultural differences, and access to care.

The Oregon Asthma Program also works with Division of Medical Assistance Program contracted health plans to improve how health systems manage people living with asthma. Evidence based interventions with health plans focus on increasing use of controller medications by people with asthma, and ensuring that people who experience an asthma exacerbation that requires a trip to the emergency department receive follow up care from their primary care doctor to adjust their medication and self management goals in order to prevent future emergency department visits. //2009//
/2010/ The rate of hospitalization for asthma among children less than five has steadily declined from a high of 18.1 per 10,000 children in 2004 to a low of 14.1 in 2008. Since 2004, the annual rate has been below the Healthy People 2010 target of 25.0. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	82.4	92.4	92.7	90.8	93.2
Numerator	18390	28594	30132	26723	32346
Denominator	22307	30945	32491	29434	34714
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008).
Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Notes - 2007
Source: Division of Medical Assistance Programs. Most recent data from CMS is 2006 .
Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Notes - 2006
Source: Division of Medical Assistance Programs, 2005.
Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Narrative:
Medicaid data is readily available from the Office of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. The requirement for EPSDT was waived in Oregon with creation of the Oregon Health Plan so no consistent data are available on the number of children who receive periodic developmental and health screens. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has initiated a Learning Collaborative around developmental screening in five counties that will provide information about the strategies and need for early and periodic screening. This project will also evaluate the reliability of data sources used to create the numerator and denominator of this measure.
Medicaid data is readily available from the Office of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. Data for Medicaid and SCHIP is not available separately to report the EPSDT rates. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has initiated a Learning Collaborative around developmental screening in five counties that will provide information about the strategies and need for early and periodic screening. This project will also evaluate the reliability of data sources used to create the numerator and denominator of this measure. The new ABCD Learning Collaborative sponsored by National Academy of State Health Policy, that Oregon is participating, will facilitate discussions and process to change how EPSDT is delivered and reporting to the state.
/2009/ The ABCD Learning Academy identified ways to track the utilization of standardized screening among Oregon Health Plan enrollees. An indicator was developed by the DMAP program to measure the rate per 10,000 children on OHP aged 6 months through 37 months old

who received a developmental screen (96110 CPT code claim). Other efforts are ongoing to train pediatricians to integrate early developmental surveillance, screening and referral in their well-child visits. //2009//

/2010/ The percent of Medicaid enrollees whose age is less than one who received at least one initial periodic screen was 93.2% in 2008, the highest percent for the 2004-2008 time period. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	92.4	92.7	90.8	93.2
Numerator	0	28594	30132	26723	32346
Denominator	1	30945	32491	29434	34714
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008). Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Notes - 2007
Source: Division of Medical Assitance Programs.

Notes - 2006
Source: Division of Medical Assistance Programs

Narrative:
See HSCI 2. Data is not available for SCHIP separate from the Medicaid/Oregon Health Plan data.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	70.0	68.1	68.3	67.5	67.5
Numerator	31828	31270	33157	33122	33122
Denominator	45501	45904	48513	49058	49058
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Oregon Center for Health Statistics. Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation. Therefore, 2008 data is not yet available.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

Narrative:
The MCH Program has direct access to the vital statistics and calculator for the Kotelchuck indices relating to the amount and adequacy of prenatal care. The data shows a decrease in this measure over the past several years. The MCH program will investigate the statistical method for accuracy and the population-based factors that may influence this trend. This investigation will include evaluating the measure by various population factors, such as age, ethnicity, race, geographical location, Medicaid eligibility and continuous enrollment throughout pregnancy, and deliveries to undocumented mothers. For comparison, the statewide percentage for first trimester prenatal care, reported in National Performance Measure 18, is showing no change over the last five years.

/2010/ The percent of women with a Kotelchuck Index of 80% or greater, declined slightly from 70.0% in 2004 to 67.5% in 2007. For 2008, we are unable to calculate this measure. The Oregon Center for Health Statistics has not finalized the computation for determining whether a woman has had first trimester care with the new birth certificate. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	77.8	80.8	80.8	77.5	70.3
Numerator	248562	242966	242966	233317	267530
Denominator	319433	300870	300870	300870	380778
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Numerator: Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008).

Denominator: Data from Population Research Center, adjusted to account for those under 200% of poverty.

Notes - 2007
Sources:
Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Notes - 2006
Sources:
Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Narrative:
The data sources for this indicator are readily available from the Office of Medical Assistance Programs (OMAP) using the Medicaid Management Information System. Capacity to outreach potentially eligible children occurs through several linking mechanisms, such as SafeNet, the MCH Toll-Free hotline, local public health nursing programs, and Headstart and other child care programs. Application assistance is available for parents at county health departments and DHS Service Delivery Area sites. Application assistance for children with special health needs is available through the same sources.

/2010/ The percent of potentially Medicaid eligible children who received a service paid for by Medicaid in 2008 was 70.3%. This is substantially lower than prior years, which ranged from a high of 80.8% to a low of 77.5%. However, caution should be exercised when making comparisons across years as methods used for 2008 may not be the the same as those used for 2004-2007. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	40.1	41.7	41.7	45.4	42.2
Numerator	21010	22301	22301	23307	21395
Denominator	52349	53543	53543	51285	50721
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Division of Medical Assistance Programs, State Fiscal Year (July 1 2007 - June 30 2008).
From 2004-2007, the percent of EPSDT eligible children aged 6 through 9 years who received

dental services during the year increased from 40.1% to 45.4%. In 2008, this percentage decreased to 42.2%.

Notes - 2007
Sources:
Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Notes - 2006
Sources:
Numerator = Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.
Denominator = Population Projects for ages 0-19. Population Research Center, Portland State University

Narrative:
This data represents those children aged 6 to 9 years who have received a dental service paid for by the Oregon Health Plan. Dental coverage for children has been increasingly reduced and outreach for enrollment continues to be limited due to budget restraints. Oregon's Oral Health Statewide Plan, along with a new broad Oral Health State Coalition, will be addressing many issues surrounding dental care for children in the next few years. The changes in the Oregon Health Plan, however, continue to cover dental services to families with up to 185% of the federal poverty level.

/2010/ The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year was 67.5% in 2008. This percentage is substantially higher than prior years, which ranged from a low of 40.1% in 2004 to a high of 45.4% in 2007. However, caution should be exercised when making comparisons across years as methods used for 2008 may not be the the same as those used for 2004-2007. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	0.0	0.0	0.0	33.8
Numerator	98	0	0	0	2569
Denominator	7508	6832	7077	7077	7593
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

This marks the first year we are using a proxy measure to assess our progress with respect to this indicator. As described in the prior year's notes, we worked collaboratively with the Oregon Department of Human Services, Disability Determination Services (DDS), to provide a letter to families of children who applied for Supplemental Security Income (SSI) benefits. The content of this letter explains to families the availability of OCCYSHN community-based programs and services. DDS began sending this letter to families beginning FY2008 (July 1, 2007). The numerator for this indicator is equal to the total number of letters sent to families of children who were newly awarded SSI benefits (n = 1,594) and to families of children who were denied SSI benefits (n = 975). The source of the numerator value was provided by DDS. The denominator for this indicator is equal to the total number of children in Oregon under the age of 16 receiving Federally administered SSI payments as of December 2008 (n = 7,593). The source of the denominator value is the Social Security Administration Supplemental Security Record, "Table—Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2008".

Notes - 2007
OCCYSHN is exploring technical assistance to develop data sources for the numerator and denominator for Oregon. for this measure.

Notes - 2006
A reliable data source is still not available for this measure. As noted in prior year, in the past OCCYSHN has generated a list of children seen at the Child Development and Rehabilitation Center clinic for rehabilitation services and has that list compared to the list of children receiving SSI from the Oregon Department of Human Services. This strategy is no longer viable in light of HIPAA and time-restraints. A proxy measure was explored. OCCYSHN has finalized the letter which DHS-SSI Office has agreed to send out indicating to families their eligibility for OCCYSHN program services as the numerator to the total number of children under the age of 16 resideing in Oregon. We anticipate the letter being implemented beginning FY2008 (July 1, 2007).

The source for our denominator is the Social Security Administration Supplemental Security Record, Table: Number of Children under the Age of 16 Receiving Federally Administered SSI Payments, December 06. When/if we the numerator, we will make the report final.

The program's ability to influence HSCI 8 is enhanced by the Oregon Medicaid Rules mandate that children who are SSI-eligible receive OHP Plus (Medicaid) coverage with no co-pay for services and the OCCYSHN Program partnership with the Oregon Children's Intensive In-Home Services (CIIS) and Oregon Seniors and People with Disabilities to inform families of the benefits available to them.

Narrative:
A reliable data source is not available for this measure. In the past, the list of children seen at the Child Development and Rehabilitation Center Clinic for rehabilitation services was compared to the list of children receiving SSI from Department of Human Services. This strategy is no longer possible because of time-restraints and HIPAA requirements. A proxy measure explored is the number of notices mailed to families regarding eligibility to CSHN program by the DHS-SSI office.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

State					
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	6.5	5.7	6

Notes - 2010
Oregon Center for Health Statistics, 2008

Narrative:
The MCH programs have access to birth certificate data used to calculate the proportion of low birthweight infants born each year by payment source to evaluate disparities in healthy births. Low birthweight rates are increasing nationally for a variety of reasons, such as shortened gestational age, medical management of pregnancy, and multiple births, but these rate have been steady in Oregon. These are issues that are generally found in the population at large, not solely in the low income and uninsured population. While the disparity between Medicaid and non-Medicaid remains constant, further analysis will be conducted to determine the particular characteristics of the disparity to better understand areas to focus capacity building. /2009/ Oregon continues to have lower low birthweight rates than the rest of the U.S. However, rates among African Americans, Native Americans and Asian/Pacific Islanders are higher than Oregon overall. (Oregon Perinatal Data Book, 2007. http://www.oregon.gov/DHS/ph/pnh/databook.shtml) //2009// .

/2010/ For 2008, the overall percent of low birthweight was 6.2 percent. However, for births covered by Medicaid, this percentage was 6.5% whereas it was only 5.9% for non-Medicaid births. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	payment source from birth certificate	6.7	5.3	5.9

Notes - 2010
Center for Health Statistics. The database for death records will complete updating more recent years for the Medicaid/non-Medicaid births in Fall 2009. The report for 2011 will update this information.

Narrative:
Oregon continues to have one of the lowest rates of infant mortality in the nation, though this trend is increasing along with the national trends in low birthweight rates.
/2009/ Infant mortality rates in Oregon continues to be lower than the U.S. except for specific races and ethnicity groups. The rate has significantly increased among African Americans and Native Americans between 1993-95 to 2002-04, and slightly increased for Asians/Pacific Islanders. (Oregon Perinatal Data Book, 2007.
http://www.oregon.gov/DHS/ph/pnh/databook.shtml) //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	66	86.8	78.4

Notes - 2010
Oregon Center for Health Statistics. Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation; therefore, 2008 data is not yet available.

Narrative:
As mentioned in National Performance Measure 18, Oregon has a specific program and statewide strategy to link women to Medicaid and insurance for first trimester care. The disparity between Medicaid and non-Medicaid may be the same as low birthweight, though Oregon has a high number of undocumented women that are not included in this data. Further analysis of pregnancy and birth-related data will be conducted over the next year.
/2009/ First trimester prenatal care indicators have shown little improvement overall, and a worsening among Medicaid-covered women. While white mothers have the best rates for early prenatal care in Oregon, it is only slightly higher than that state average overall. Native Americans have the worse rate of first trimester care, with African Americans and Hispanic mothers with second worse rate of care. Approximately 8.2% of women who gave birth in Oregon reported having no insurance for the prenatal care services, while approximately 39% used the Oregon Health Plan/Medicaid. More than one-fourth of Hispanic women (28.7% in 2004) had no insurance for prenatal care, which is 3.5 times higher than the national average. Native Americans and African American women were significantly more likely to use the Oregon health Plan to pay for the prenatal care services than other race/ethnic groups. (Oregon Perinatal Data Book, 2007. http://www.oregon.gov/DHS/ph/pnh/databook.shtml) //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to	2007	payment source from birth certificate	60.6	72.2	67.5

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2010
Oregon Center for Health Statistics. Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation; therefore, 2008 data is not yet available.

Narrative:
As mentioned in National Performance Measure 18, Oregon has a specific program and statewide strategy to link non-Medicaid and Medicaid eligible women to prenatal care. As described in HSCI 05C, the disparity between Medicaid and non-Medicaid may be influenced by high number of undocumented women with live births that are included in the non-Medicaid population to analyze adequacy of prenatal care visits for this population, however, further analysis of pregnancy and birth-related data will be conducted over the next year.
/2009/ The Oregon Perinatal Data Book provides analysis of the gap between first trimester initiation of prenatal care and adequate prenatal care. In 2004, white mothers had the highest prevalence of both first trimester prenatal care initiation (84%) and adequate prenatal care (74%). Both Hispanic and Native American mothers were less likely to receive either first trimester care or adequate prenatal care compared to mothers of other race/ethnic groups, and approximately 40% of both groups did not receive adequate prenatal care. The trends for this indicator for 2007 shows a small decline from previous years. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	185

Narrative:
SCHIP is rolled into the Oregon Health Plan for the eligibility for all populations. Higher federal poverty rates are set for children under 5 years and for pregnant women, than for children 6-18 years and the rest of the adult population. The Oregon Title V Director participates in the state-level DHS Medicaid Advisory Committee that meets monthly for the purpose of discussion and recommendation of policy issues to the DHS Cabinet, and therefore has input into decisions regarding coverage and coordination of services for the MCH population.

The Oregon Health Plan (Medicaid waiver) was covered pregnant women and young children up to up to 185% FPL, until 2003. Budget reductions at the state and national level forced a reduction of these rates to Medicaid levels. The OHP benefit packages were split into two tiers -- OHP Plus and OHP Standard.

The former Basic package, renamed OHP Plus, covers the same services for categorically eligible clients. A new benefit package, OHP Standard, was created and offers reduced benefits, higher co-payments and requires premiums. Starting June 1, 2006, OHP no longer charges a

premium to OHP Standard clients whose household income is 10% or less of the Federal Poverty Level (FPL). Clients on the OHP Standard benefit package whose income is above 10% FPL must now pay current and past-due premiums at the time of reapplication in order to remain eligible for continued OHP Standard coverage. Starting June 1, 2006, client eligibility for the CHIP program is extended from 6 months to 12 months.

The Centers for Medicare and Medicaid Services (CMS) granted Oregon another five-year waiver on October 15, 2002. Most Oregonians eligible for the Oregon Health Plan's Medicaid coverage now receive the OHP Plus benefit package. Clients receiving the Plus Benefit Package include children under 19, pregnant women, blind, aged, people with disabilities, and other special need populations. Individuals and families with income below federal poverty guidelines are eligible for OHP Medicaid coverage. Pregnant women and children under 19 in households with earnings up to 185 % FPL are also eligible.

The Family Health Insurance Assistance Program (FHIAP) subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums. CMS approved the waivers for federal matching funds for FHIAP on October 15, 2002, and FHIAP implemented the waivers beginning November 1, 2002. Since then, FHIAP new enrollments have qualified for either CHIP or Medicaid match rates. These savings help fund expansion of FHIAP over the five-year demonstration period. FHIAP subsidies range from 95% of the premium cost (for families up to 125% FPL) to 50% of the premium cost (for families up to 185% FPL).

Source: "The Oregon Health Plan: An Historical Overview"
http://www.oregon.gov/DHS/healthplan/data_pubs/main.shtml

These changes in the Oregon Health Plan over the last few years have created some confusion among families and health providers. In some families, the children qualify for OHP health insurance without a co-pay, but the parents do not qualify for their own health insurance, or must provide a co-pay. Outreach efforts are underway to raise awareness among families and health providers to assure all eligible children have access to health care and health insurance, especially those under 5 for the full 12 months.

/2009/ No changes in the coverage level for Medicaid-Oregon Health Plan. However, the DMAP set up a reservation list to add an average monthly enrollment in Oregon Health Plan-Standard plan of 24,000 by November, 2008. DMAP created a reservation list from which names would be drawn randomly to receive an application for OHP coverage. To date, 91,000 people submitted applications to be on the reservation list, and 15,000 have been drawn and sent applications. As a result, 3,084 have enrolled for medical coverage. (DHS News Release, July 7, 2008. http://www.oregon.gov/DHS/news/2008news/index.shtml) //2009//

/2010/ Healthy Kids Plan provides legal authority and funding to enroll eligible children and provide safety net primary care to ineligible children. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to)	2008	100

(Age range to)		
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	185

Narrative:
Oregon's SCHIP program is combined with the Oregon Health Plan. Information is about SCHIP is included in HSCI #06A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	185

Narrative:
Oregon's SCHIP program is combined with the Oregon Health Plan. Information is about SCHIP is included in HSCI #06A.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC	3	Yes

eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:

- Oregon's data capacity to measure the eleven indicators is contingent on access to a number of data sources. The OFH currently has access to data from FamilyNet client data including WIC client data ("TWIST"), Immunization client (IRIS) and registry (ALERT) data, EHDI (Early Newborn Hearing Detection Intervention) data, linked newborn screening and birth certificate data, Ahlers Family Planning client data, birth and death statistics, OMAP (Office of Medical Assistance Programs - Medicaid) data, hospital discharge data, PRAMS surveys, BRFSS surveys, and Oregon Healthy Teen (YRBS) Survey data. For children with special health needs programs, located at the Child Development and Rehabilitation Center at OHSU, Oregon Health Plan data is available to track early intervention, screening, diagnosis, referral and follow up for a variety of health and oral health issues. Oregon was approved but not funded by CDC for a Birth Defects Registry two years in a row, and will continue to submit applications.
- Vital Statistics-Public Health data warehouse: VistaPH is a web-based, user-friendly software package that allows the public health community in Oregon to access and analyze population-based health data on the county or state level. The program calculates rates of disease or other health events for specific age, gender and race groups with appropriate statistical measures: confidence intervals, case counts, and time trends. Oregon data sets currently available for analysis through VistaPH include birth, death, infant mortality, communicable disease and population estimates. Future plans for the initiative include making VistaPH available to additional counties, adding more data sets, and allowing analysis on sub-county geographic levels.
- Oregon's integrated data system, FamilyNet and ORCHIDS (Oregon Child Health Information Data System) is being developed to support and evaluate an integrated system of services in which all children, pregnant women, and families at risk are identified as early as possible, and services needed for optimal health and development are available and accessible. ORCHIDS will contain case based and aggregate, population, screening, follow-up, and care coordination data from seven different perinatal and child health programs. Programs included in FamilyNet the Early Hearing Detection & Intervention (EHDI); reporting and long term care coordination related to newborn dried blood spot screening (newborn metabolic, hemoglobin, and endocrine disorders screening); public health care coordination for children with special health needs (CaCOON and Community Connections Network); high risk infant follow up (Babies First!); prenatal care access (Mother's Care); care management for high-risk pregnant women (Maternity Case Management); and community support for families with social and economic risk factors (Healthy Start). /2009/ Full roll out and participation in ORCHIDS occurred in May 2008 //2009//

/2009/ PRAMS_2: In September 2005, Oregon PRAMS began re-surveying PRAMS respondents when their child turned 24 months old. The survey includes questions on health insurance, chronic diseases, oral health, well child care, medical home, breastfeeding, smoking, domestic violence, family planning, child nutrition, immunization, early intervention, childcare,

screen time, and reading to child. Up to two mailings of the PRAMS-2 surveys are sent for each mother, then a telephone follow-up to non-responders. The response rate is 57%. Data on 2006 surveys (for babies born in 2004) have been available since July 2008. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
Oregon MCH Programs have electronic access to the Oregon Healthy Teens Survey (Oregon's YRBS system) to monitor health status for 8th and 11th graders. Program managers and research staff participate on the collaborative group charged with development and analysis of the survey.
The Oregon Healthy Teens Survey (OHT) is the one state-sponsored survey designed to monitor the health and well being of adolescents (Oregon's Youth Risk Behavior Survey). An anonymous and voluntary research-based survey, the OHT is designed and administered through a collaborative group of Oregon state agencies including the Department of Human Services, the Department of Education, the Governor's Commission on Juvenile Justice, the Commission on Children and Families and the Oregon Progress Board. The survey instruments have been revised annually since 1991 and this year consisted of one version for both 8th and 11th graders, containing 189 separate response items.

The OHT survey was surveys about four in ten of all 8th and 11th graders statewide. Surveyed schools were selected through five processes: As part of a statewide random sample, as part of the sample for Center for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS), as a Coordinated School Health (CSH) school, as part of the Oregon Research Institute (ORI) Tobacco Prevention evaluation (there was some overlap between these first four groups) or as a volunteer school. The surveys were conducted by either Oregon Research Institute, for schools under their funding, or by a private contractor to DHS, who instructed classroom teachers in proctoring the survey.

In 2005, surveys were returned from 30,002 students, representing an overall response rate of 79.5% of those sampled. Of these, 3.2% were excluded because of extensive patterns of discrepant and/or dubious (extreme) answers, 4.8% were excluded because their grade level could not be determined or because of missing gender information. This left 27,622 valid surveys: 92.1% of the total received, with 14,708 from 8th grade, 11,028 from 11th grade, and 1,886 from 9th, 10th, and 12th grade as part of the YRBS sample, in 34 counties. There was no data collected at all from 2 counties, Lincoln and Josephine counties, and Tillamook County had no 11th grade data.
(source: http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/index.shtml)

/2009/ The 2006 Oregon Healthy Teens survey was conducted among over four in ten of all 8th and 11th graders statewide. Surveyed schools were selected through four processes: As part of a statewide random sample, as a Coordinated School Health (CSH) school, as part of the Oregon Research Institute (ORI) Prevention evaluation (there was some overlap between these three groups) or as a volunteer school. The surveys were conducted by a private contractor to DHS, who instructed classroom teachers in proctoring the survey. Surveys were returned from nearly 29,000 students, representing an overall response rate of 81.2% of those sampled. Of these, 3.0% were excluded because of extensive patterns of discrepant and/or dubious (extreme)

answers, while 5.8% were excluded because their grade level could not be determined or because of missing gender information. This left 26,440 valid surveys (91.2% of the total received, with 15,291 from 8th grade and 10,676 from 11th grade in 32 counties. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The 2001-2006 Family and Child Health (Title V) Needs Assessment established priority needs in Oregon. The State Negotiated Measures represent indicators that meet OFH selection criteria: measures that relate to OFH and DHS priorities for which data are valid, currently available in Oregon, planned to be reliably tracked over five years, and related to evidence of favorable program outcomes. The State Negotiated Measures were also selected for their relevance to the Oregon Benchmarks and priorities, a statewide quality of life measure system coordinated through the Governor's office. A "MCH Monitoring System" created through the SSDI initiatives, maintains definitions of all performance measures, high level outcomes, and intermediate level outcomes, and the measure's relationship to agency or grant requirements such as the Oregon Benchmarks, Oregon Dept. of Human Services, Title V, and other federal, state or projects.

2001-2006 State Performance Measures
The ten state measures from the 2001-2006 were based on the priorities from the Family and Child Needs Assessment and on validity of data sources to measure progress over the five year time period. The state negotiated measures and their supporting activities reflect the focus of MCH programs in OFH and OCCYSHN to build infrastructure in public health systems for better service delivery and in improving population health through better program delivery. Measures related to pregnancy health, injury prevention, tobacco use, and water fluoridation are directly related to the reducing mortality rates, or the underlying morbidities, represented by the six Core Outcome measures. The other measures are related to building infrastructure to address MCH population needs. In Oregon, the focus of MCH infrastructure building is on access to care, enhancing of communication with and information for providers, and data capacity to better analyze indicators and outcomes in the future.

The 2005-06 Priorities Background and Overview:
The selection of health priority needs for the 2006 Needs Assessment began with a review and evaluation of work conducted by other offices and agencies during 2004-05. The Local Public Health Agency Plans, the CCF Plans, and other similar documents were reviewed and compiled to determine the highest priority issues felt by Oregon communities. The information from these documents was synthesized to develop the leading priorities most recently assessed by local agencies. A list of health topics was identified as leading problems or assets for Oregonians. These topics included: Insurance coverage and access to care; Perinatal care; Mental and emotional health; Substance abuse; Injury; Oral health; Obesity and nutrition; Health disparities; Prevention and screening; Reproductive health; Chronic disease prevention; Other: communicable disease, environmental health, geriatrics.

From these issues, overall priorities for Title V were discussed and prioritized among work groups formed around MCH populations and resulting in a selection of "aims". An aim is similar to a goal but it is measurable and active, and is intended to serve as an over-arching focus for performance or outcome measures. Criteria for the aims included:
-- Importance: Based on health status indicator data, does the health topic significantly impact a large number or of a vulnerable sub-population of Oregonians (health disparity)?
-- Ability to Impact: Can the health topic be improved upon in 5 years?
-- Measurability: Can we measure the impact that we make?
-- Leverage: Do current opportunities or resources (such as current efforts or initiative, funding, public awareness or political will) exist to leverage the impact of working on the topic?
-- Alignment with State Agency Priorities: Does work on this topic promote and/or support the governor's and/or other state agencies goals and policy agendas?
-- Alignment with Other Partners' Priorities: Does work on this topic address an issue of stated importance to our Local Health Departments or other partners?
-- Impact on OFH programs: Will working on the topic build, expand, or shift the current work of OFH programs in a direction consistent with our values and mission?

The Aims selected are:
- Children's health needs are always met.
- Individuals and families exhibit healthy lifestyles.
- Children, adolescents and families experience optimal mental health and social emotional development.
- Parents and providers are confident in caring for children.
- Racial and ethnic disparities are eliminated (cross-cutting)
- Strong leadership is helping to reduce morbidity and mortality of the maternal and child health population (cross-cutting).

During the interim needs assessment years, the Oregon Title V Program will work to build the program and resource allocation necessary to address needs that will contribute towards the positive impact toward Oregon's National and State Negotiated Performance Measure objectives.

/2007/ The Office of Family Health is using the Capacity Assessment results to discuss and plan for better use of existing staff resources and needs for internal systems changes. Three areas being reviewed are: policy development and advocacy, program evaluation, and organizational structure. //2007//

/2007/OCCYSHN incorporates an evaluation process in each of its activities to assess the priorities and measure success toward the performance measure objectives and program outcomes. Mental health and dental health are identified as needs children and youth with special health needs, as well as the general child and youth population. Training and technical assistance to address the concern of mental health issues were pursued this past year and partnerships formed to develop effective strategies and system of care. //2007//

/2008/ OFH continues to work towards building competencies around program evaluation. Managers and program staff attended the CDC Program Evaluation Training in Fall, 2007 and Spring, 2008, and worked to improve integration of program evaluation practices in OFH programs and structure. //2008//

/2009/ A new Evaluation Manager is hired and will begin to develop an organizational structure for MCH programs, Office of Family Health, and Title V activities. //2009//

/2010/ The OFH Title V Program is readying its 2010 needs assessment and is using the priorities and the previous assessment will be utilized as baseline information. Another capacity assessment will be conducted within the Title V program to determine needs in capacity for the next five-year cycle. //2010//

/2008/. During 2007, OCCYSHN community consultants found a need to increase emphasis on behavioral health, family involvement, access and adolescent transition. OCCYSHN is planning for community engagement processes to these priority issues for children/youth with special needs.
- OCCYSHN disseminated information and facts to educate legislators and the public about children/youth with special needs. In addition, OCCYSHN will seek involvement in rulemaking processes and provide information to providers and the public about the affect of legislative changes on children/youth with disabilities or chronic conditions and their families. //2008//

/2009/ During 2008, through conversations with county public health leaders, oral health has emerged as a critical need for children with special health needs. OCCYSHN will look to AMCHP for assistance in determining an effective method for gaining traction in Oregon around this issue. OCCYSHN will partner with the OFH in its oral health coalition on behalf of all children, and to develop opportunities to increase awareness of the need for oral health services for CYSHN and to increase the skills and knowledge of oral health professionals in serving CYSHN. Family

involvement and cultural competency in care for CYSHN remain priority needs in addition behavioral health, adolescent transition and health care finance.
//2009//

B. State Priorities

Background on 2006-2011 State Priorities:
The 2005-06 Needs Assessment conducted an extensive capacity assessment for providing all levels of the Title V Pyramid of Services. The information from these capacity assessments will provide direction during the interim years to develop the programs, services and resource allocation that best contribute towards the state's performance measures. The greatest need from these capacity assessments was in the area of mobilizing partnerships, including with families, at the state and local levels, and in program evaluation and continuous improvement systems.

The overarching Aims selected in 2005 will provide guidance for Oregon's Title V programs through selection of additional program-level performance measures and evaluation. The state performance measures selected to represent these aims are intended to be the best indicators available for those aims. The Title V State Performance Measures are viewed as "intermediate" measures that are not ends in themselves, but rather the best indicators to monitor progress of efforts among state and local public health partners.

An exception to the list of State Performance Measures is the absence of a mental health performance measure. Mental health status for children, adolescents, pregnant women, and children with special health needs does not have reliable and valid data sources to acceptably measure progress toward improvement. An emotional health and mental health status measure would have been included in the state measures. However, mental health wellness and access to mental health services repeatedly arises as one of the top needs by families and by providers serving those families. Oregon Title V program therefore added mental health in its list of priorities, without a supported performance measure, with the commitment to actively work to develop appropriate measures during the interim years. The MCH Block Grant interim year updates will report progress in developing these measures.

/2010/ The 2010 needs assessment will include evaluation of the 2005 priorities. //2010//

The 10 state performance measures for 2006-2011 are listed below with their relationships with the 6 Aims selected through the needs assessment process.

Priority 1: Improve access to comprehensive and coordinated health care; facilitate screening, assessment and intervention services

/2010/ Oregon participated in the National Academy of State Health Policy ABCD Learning Collaborative in 2007-2008. This Academy was successful in bringing together Medicaid, Oregon Pediatric Society, Early Intervention, Children with Special Health Needs programs to build a system of screening, referral and follow--up. As a result of this project, pediatrician leaders and managed care organizations developed a performance improvement project and curriculum to educate providers in the structured, standardized developmental screening process. Additionally, Early Intervention (Part C) services, the Pediatric Chapter and the Title V program developed a universal screening, referral and feedback form for primary care providers. The forms include parent consent for sharing information that complies with both FERPA and HIPAA regulations and documents the reason for referral, whether medical diagnosis or screening scores. These actions are spreading through the advocacy of both pediatrics and early intervention providers. //2010//

SPM # 3: Percent of infants diagnosed with hearing loss that are enrolled in Early Intervention before 6 months of age
Population groups affected: Infants, Children, Children with Special Health Needs

SPM # 4: Percent of children that complete the 4th DTAP vaccine (12-18 months)
Population groups affected: Infants, Children

SPM # 6: Percent of 11th graders who report having unmet health care needs
Population groups affected: Children and Adolescents

Priority 2: Support behaviors and environments that encourage wellness and reduce chronic disease.

SPM # 7: Percent of Oregonians living in a community where the water system is optimally fluoridated
Population groups affected: Infants, Children, Children with Special Health Needs, Pregnant Women

SPM # 2: Percent of smoking pregnant women who quit smoking during pregnancy and remained quit
Population groups affected: Women, Pregnant Women, Infants

SPM # 1: Percent of births that are intended
Population groups affected: Infants, Children, Adolescents, Women

SPM # 5: Percent of 8th graders who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days.
Population groups affected: Children, Adolescents

Priority 3: Promote optimal mental health and social emotional development.
Population groups affected: Pregnant Women, Infants, Children, and Adolescents

For this priority, the Oregon Title V Program is committed to improving mental health status of mothers and children. The Program recognizes the current lack of reliable, valid population-based data to measure performance. In the next five years, the Title V Program will work to develop infrastructure, measures, and activities, integrated and linked with services reaching this population, in areas such as:
- Maternal depression
- Social-emotional health of young children
- Social-emotional health of adolescents

/2007/ With the completion of the Early Comprehensive Childhood Systems (ECCS) Plan, the Office of Family Health and Title V Programs are positioned to begin working on mental health issues. In addition, analysis of Oregon's data from the National Survey of Children's Health and the Oregon Healthy Teens Survey (YRBS) will provide baselines to help bring focus to the discussion. //2007//

/2008/ The Governor's Children's Wraparound Services Initiative committee work on mental health services is represented by the ECCS coordinator and Adolescent Health Manager from OFH. //2008//
/2008/ The Adolescent Health Program added a mental health component to the Coordinated School Health program for the first time in the 2006-07 school year in 4 schools. A school mental health self-assessment and planning tool modeled after the CDC School Health Index was developed and pilot tested by 3 schools and 1 district behavioral program during the 2006-2007

academic year. This tool will be implemented widely in 2008 and the results will be used to help each school plan, strategize and further a coordinated school health approach to mental health services in their school. A School Based Health Center Mental Health Needs Assessment online survey was completed by each of the SBHCs to assess in detail their mental health staffing and capacity in order to understand where gaps exist. This information will be used to provide technical assistance and training to SBHCs in having better organization of existing mental health services, as well as serving as a capacity baseline when planning for future mental health services. //2008//

/2009/ Substantial progress in finding a mental health indicator was made in 2007-9. As a result of the ABCD Learning Academy, a measure for screening Medicaid-covered children in well-child care has been developed, using the 96110 CPT code. This will allow the MCH program to track the use of standardized screening in well-child visits, as providers increasingly use this code for billing. Additional work in screening social/emotional development and perinatal mood disorder is underway in 2008, as shared planning with county public health nurses proceeds and the ABCD Screening Initiative and public-private partnership continues in 2008-09. //2009//

/2009/ The Adolescent Coordinated School Health program asks participating schools to report on Oregon Healthy Teens indicators related to mental health status. These indicators include questions about mood, suicidal ideation, and unmet mental health needs. /2009//

/2010/ In review of the goal to find a mental health indicator, the Oregon Title V Program areas have gotten closer to identifying activities that take a public health approach to mental health issues. Overall, these activities include building partnerships with primary care and mental health providers, building data sources to monitor populations (mothers, early childhood, and adolescents) and strategizing resource allocation to develop policies and programs that address mental health issues. External to Title V, policy efforts have moved toward development of an "integrated health home" within primary care settings. Legislation was passed directing the Dept. of Human Services to research and recommend payment structures within the Oregon Health Plan to reimburse services conducted in an integrated health home setting, and present a report to the 2011 Legislature (HB 3418). During the course of the 2010 Title V Needs Assessment, population-based mental health issues will be included in the overall assessment of priorities. //2010//

Priority 4: Parents and providers are confident in caring for their children

SPM# 8: Percent of health care providers who report confidence in caring for CYSHN and their families
Population groups affected: Children with Special Health Needs

/2008/ OCCYSHN is initiating development of a measure of provider confidence to better assess State Performance Measure #8: Providers are confident in the care of CYSHN. With assistance from OPER and CAHMI, OCCYSHN aims to develop and validate a measure of provider confidence by the middle of the 2008 program year. //2008//

/2009/ The measure of provider confidence has been off set this past program year and is being conducted by a simple self-report. OCCYSHN will review this performance measure and develop an alternative performance measure around providers' confidence and competence, their adequate preparation to care for CYSHN and their families.//2009//

/2010/ OCCSYHN is piloting the use of a new measure of provider confidence. Two weeks after completing a training, participants receive a follow-up evaluation survey which includes an item asking to rate their level of increased confidence in caring for children in relation to the training topic. During 2010, the program will aim to develop a more robust measure of provider confidence and/or competence. During the upcoming five year needs assessment, an alternative performance measure may be identified. //2010//

SPM # 9: Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.
Population groups affected: Children with Special Health Needs

SPM # 10 Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.
Population groups affected: Children with Special Health Needs

Cross-cutting priorities - Performance and outcome measures, activities and resources, and on-going needs assessment will be developed to address the following priorities across all performance measures:

Priority 5: Promote equity in health by reducing disparities; promote equity means to create policies, systems and resources.

Priority 6: Advocate public health within existing systems; promote the role of public health and Office of Family Health as a partner in early childhood services and systems.

/2007/ The OFH Title V program in the Office of Family Health has been working on capacity priorities identified in the needs assessment, to develop structures that will better address the health priority issues. During 2006-07, the Title V Program, OCCYSHN, and local public health nurses and administrators will engage in joint priority setting and strategic planning to better align state and local MCH services and programs according to these priorities. OCCYSHN is collaborating with private groups and public agencies to explore the health access concerns for CYSHN as related to insurance coverage, training for providers and assessing capacity of nursing groups (school nursing, home health nurse and public health nurses) to address care coordination needs. //2007//

/2008/ OFH initiated an internal Policy Case Study Series for staff to provide information and training about policy development and leadership. The case study format is intended to provide a practical approach to increasing knowledge and competency in policy development and implementation, especially in the context of a government public health agency. //2008//

/2008/ Oregon's Early Comprehensive Childhood Systems Plan has entered its implementation phase. The Plan's shared objectives and strategies are being confirmed and incorporated into Title V program planning in OFH and OCCYSHN activities. A significant step in the ECCS Plan implementation is Oregon's award to participate in the ABCD Learning Academy sponsored by the National Academy of State Health Policy to improve and standardize early childhood developmental and psychosocial screening in Oregon. The Title V Program (OCCYSHN and OFH) is a co-leader with the State Medicaid Program and the Oregon Pediatric Society to participate in the Academy, and together they will lead development of a public-private stakeholder group, oversee a pilot to evaluate use of standardized screening tools and referrals, and develop strategies to spread the practice across Oregon's early childhood system of care. The strategies will include recommending policy changes to support the implementation of standardized developmental screening as a standard practice in well-child care. This opportunity became available at the right time in Oregon, as similar pilots upon which to build have already occurred in both pediatric and family practice settings, and it is a direct implementation of the ECCS recommendation to "promote the use of standardized developmental and psychosocial screening tools as routine components of well-child check-ups and community services." The ABCD initiative also addresses all the Title V priorities in multiple ways, from providing MCH leadership and facilitation to engage new partners (Pediatric Society and Medicaid) to improving screening, social/emotional development, and parent and provider confidence in caring for children.

Other early childhood activities supporting the recommendations and goals of the ECCS Plan reflect the value of engaging a broad cross-section of stakeholders and leaders in development and ongoing refinement of the plan. The Title V Director, the ECCS Manager, and other Title V and public health staff are involved in these activities at multiple levels, including policy development, technical assistance for community planning, infrastructure enhancement, and service delivery system collaboration. State and local partners, as well as Oregon's emerging public-private partnership, have endorsed the ECCS Plan's framework and are working to align their early childhood activities with it.

Two efforts occurring at the Governor level are The National Governors Association (NGA) award for a Governor's Summit on Early Childhood and the Children's Statewide Wraparound Project. The Children's Wraparound Project was initiated by Executive Order 07-04 proclaiming the need for a statewide, integrated system of care for children and their families at risk for emotional, behavioral or substance abuse related needs. The EO established a Steering Committee and requires a report by December 2007 that lays out recommendations and a plan to finance and provide accountability for statewide emotional and behavioral health services for children, adolescents and their families that reflect values and wraparound principles. The Title V Director, ECCS Manager, and Child and Adolescent Health staff is involved in this initiative.

The NGA has awarded Oregon funds to hold a Governor's Summit on Early Childhood. The focus of this summit is to further the Governor's policy agenda and recent legislative action aimed to improve the health and well-being of young children at risk. The Summit will focus primarily on social/emotional -development and early childhood mental health, and is integrated with the Children's Wraparound Initiative. //2008//

/2009/ The Governor's Summit was held in March 2008 and resulted in a restructuring and development of a private-public leadership and work group to work on three different areas: health, parent education, and family support. The ECCS Project Manager is co-lead for the health work group. //2009//

/2010/ The ECCS project continues to be a lead participant in the statewide early childhood efforts, including the Early Childhood Council -- a statewide council of public and private partners interested in participating in planning and implementation of early childhood policy priorities. The ECCS project coordinator is co-lead of the "Health Matters" committee. Other committees include "Family Matters" and "Education Matters". Title V and ECCS staff will continue to work towards coordination within the Dept of Human Services and in sustaining public-private partnerships throughout the early childhood services system. //2010//

/2008/ In 2006-2007, the Title V Program initiated a comprehensive, in-depth look at the health status of pregnant women and birth outcomes in Oregon to explore priorities and needs. This information is being captured in The Oregon Perinatal Data Book. The Data Book is comprised of leading perinatal health indicators that describe the overall picture of perinatal health in Oregon, with data obtained from Vital Statistics, PRAMS, and the National Immunization Survey. The information covers demographics of Oregons child-bearing population, perinatal health, birth outcomes, and maternal and infant health. The data and graphic charts show comparisons with national data and the Healthy People 2010 goals to bring perspective to the data and how close Oregon is achieving those goals. Trends, include 10-year trends when available, give a picture of any significant changes over time.

The Perinatal Health Data Book will be disseminated widely among policy and program developers and decision makers. The data will be directly used in a state-local priority and planning initiative between the Title V program and the Association of Oregon Public Health Nurses. The data has shown worsening trends in low birthweight infants and access to early and adequate prenatal care, particularly among low-income women. The shared goal and priority setting by Title V-AOPHNS, to occur in Fall 2007, will result in consensus on the interventions

and best practices targeted specifically to improve trends in perinatal health. //2008//

/2009/ The Perinatal Health Data Book was completed in late 2007. It has been disseminated among local and public policy makers and stakeholders, as well as being used for developing grant and legislative proposals. The analysis was instrumental in helping the public health nurse shared planning group determine areas of perinatal health to develop strategic plans. More on this in III.A. State Overview. //2009//

/2008/ The Adolescent Health Program is working in ongoing needs assessment and priority setting include the efforts by incorporating Youth Action Research methods to identify needs, priorities and goals based on the input of youth. The information from this research will be used to the development of strategies and policy recommendations for the new teen pregnancy prevention/adolescent sexual health State Plan.//2008//

/2008/ To improve MCH Leadership capacity in Title V Programs, OFH and OCCYSHN staff and managers are attending both Public Health Leadership and MCH Leadership programs. During 2006-2007, three people attended the year-long Northwest Center for Public Health Practice, two attended the National MCH Leadership Academy, and three people participated in the Dept of Human Services Leadership training. //2008//

/2009/ The OCCYSHN Program Manager (now appointed as Director) attended the MCH Leadership Academy in Fall 2007 and is now making her application to the New Director's Mentor Program for the Fall/Winter of FY09. The new MCH Section Manager attended the MCH Leadership Academy of June 2008. //2009//

/2010/ To increase leadership capabilities within the OCCYSHN program, program staff participated in a two day staff development retreat focusing on an update on maternal and child health mandates, concepts and practices of public health, the Title V pyramid and the application of data in improving systems of care at the local level. The Director of the Office of Family Health presented on the OFH MCH program and practices and the relationship between the two State Title V programs. During 2009 and continuing with 2010, the OCCYSHN Director is participating the New MCH Directors mentor relationship with Phyllis Sloyer, Florida MCH Director, and is planning a site visit and participation in a learning collaborative on development of new and innovative community-based programs for CYSHN. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	24	48	36	60	51
Denominator	24	48	36	60	51
Data Source					Or Public Health Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Source: Newborn Screening

a. Last Year's Accomplishments
Note on data: The Newborn Screening program screens every child born in Oregon, including those who are residents of other states.

- Oregon continued to participate in the Northwest Regional Newborn Screening Program, administered by the Oregon State Public Health Laboratory (OSPHL). All 29 of the conditions recommended by the American College of Medical Genetics are included in the screening panel. Systems are in place to assure that all infants with a positive test result receive appropriate diagnostic testing, and that a health care provider accepts responsibility for treatment and/or monitoring. The primary care physicians of all children with metabolic conditions requiring treatment or monitoring are offered long-term follow-up through the OHSU/CDRC metabolic clinic, the only comprehensive metabolic center in the state. Block Grant funds partially support the metabolic clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by newborn screening are offered long term follow-up through the OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs.
- Access to treatment/management services for children with conditions detected by newborn screening was improved by providing ten visits by telemedicine with a metabolic geneticist and/or metabolic dietician for children living in Bend, Medford, and Eugene. All families reported confidence in the quality of care they received at the visit and that they would recommend telemedicine to other families.
- To assure coordinated care for children with conditions detected by newborn blood spot screening, the CaCoon Public Nurse Home Visiting Program continued to provide community-based care coordination and follow-up for qualified children.
- To assure children with conditions detected by NBS receive treatment, public and private third party payers are required by state law to cover medical food and formula for individuals born with errors in metabolism needing medical food for optimal growth and development. The Oregon WIC program and CDRC Metabolic clinic continued to provide medical formula for eligible infants/children under age five with inborn errors in the metabolism. The CDRC Metabolic nutritionist promoted a national policy of third party reimbursement for medical foods.
- To assure access to accurate, timely information about newborn screening for the public, parents of infants with positive newborn screening results, and healthcare professionals, the OSPHL NBS program website was maintained including information for parents, fact sheets for health care providers about each condition screened for, and a healthcare Practitioners' Manual. A page on newborn screening was added to the "Prenatal and Newborn Resource Guide for Oregon Families". The guide is given to all mothers of Oregon newborns, is produced in English and Spanish, and is posted on the Oregon state website.
- The OSPHL continued offering WebRad, a secured web-based tool giving hospitals and physicians the ability to obtain newborn screening test results when ever they are needed.
- The OSPHL, OFH, and CDRC staff members continued participation in the Western States Genetic Services Collaborative (WSGSC), a HRSA-funded Cooperative Agreement. Staff members also participated in multiple NBS-specific committees and work groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. State law mandates that all newborns receive metabolic screening			X	
2. Contractual partnerships between Oregon State Lab and CDRC/OHSU	X			X
3. Practitioner manuals updated and distributed throughout the state; online resources available			X	
4. Collaboration between CDRC Metabolic clinic and WIC to assure medical Collaboration between CDRC Metabolic Clinic and WIC to assure medical formula provided for infants/children under the age of five with metabolic disorders of metabolism (e.g.:PKU)		X		
5. Assure follow-up and treatment through CaCoon, Community Connections Network and CDRC Genetics and Metabolic Clinics	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Systems continued to be in place to assure all infants with positive NBS results receive appropriate diagnostic testing and a health care provider accepts responsibility for treatment/monitoring.
- Activities to assure that children diagnosed with conditions detected by NBS receive treatment included providing five telemedicine visits with a metabolic geneticist and/or dietician, and the Oregon WIC program and CDRC Metabolic clinic providing medical formula for eligible infants/children under age five.
- To assure access to accurate, timely information about NBS, information for parents and healthcare providers was maintained on the OSPHL website.
- Secure on-line access to newborn screening results was provided to hospitals and physicians.
- To improve tracking of outcomes and services provided to children with conditions detected by NBS, and to assure eligibility of these children for the CaCOON program "Positive Newborn Blood Screen" was added to the CaCoon Eligibility List, a combined document of Babies First! and CaCoon. Also, the CDRC metabolic clinic began entering information on individuals followed through the clinic into a long-term follow-up database. Informed consent is required prior to data entry.
- The Oregon NBS program is participating in a multi-state HRSA-funded grant aimed at improving the experiences of parents whose children receive positive NBS results.

c. Plan for the Coming Year

- The current newborn screening panel including the 29 conditions recommended by the American College of Medical Genetics will continue next year.
- Primary care physicians of all children with metabolic conditions requiring treatment or monitoring will continue to be offered care through the OHSU/CDRC Metabolic Clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by newborn screening will continue to be offered care through the OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs. Offering telemedicine visits for children with metabolic conditions will be discontinued because program evaluation data revealed that at least $1,500 of staff time and other costs was required per telemedicine visit in addition to the resources needed to support routine CDRC metabolic clinic services.
- CaCoon Public Nurse Home Visiting Program will continue to offer community-based care coordination and follow-up for children with conditions detected by newborn screening. The CaCoon Public Nurse Home Visiting Program and Community Connections Network staffs will continue to enter data for children with conditions detected by newborn screening that are served

by these programs into the Oregon Community Health Integrated Data System (ORCHIDS).
- The Oregon WIC program and CDRC Metabolic Clinic will continue to provide medical formula for eligible infants/children under the age of five who have inborn errors of metabolism. The CDRC metabolic nutritionist will monitor third party reimbursement for metabolic foods and formula, and to promote a national policy of third party reimbursement for medical foods.
- NBS information for the public, parents, and health care providers will be maintained on the OSPHL NBS program website, http://www.oregon.gov/DHS/ph/phl/.
- The OSPHL will continue to offer WebRad, a secured web-based tool giving hospitals and physicians the ability to obtain newborn screening test results for their patients.
- OSPHL, OFH, and CDRC staff members will continue participation in the Western States Genetic Services Collaborative, and other regional and national work groups and committees.
- OSPHL and CDRC staffs will continue to participate in multiple regional and national newborn screening-related committees and workgroups, including those on emergency preparedness and long term newborn screening follow up.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	57	59	55	55	56
Annual Indicator	54.6	54.6	54.6	55.5	55.5
Numerator	62990	62990	62990		
Denominator	115367	115367	115367		
Data Source					2005/06 NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	57	57	57	57	57

Notes - 2008
Similar to national estimates (57.5 percent), slightly more than half of Oregon families of CSHCN (55.5 percent) indicate they are partners in decision making at all levels and are satisfied with services they receive.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

Note on data: Similar to national estimates (57.5 percent), slightly more than half of Oregon families of CSHCN (55.5 percent) indicate they are partners in decision making at all levels and are satisfied with services they receive.

- The Family Involvement Network grew to 50 families who participated in a variety of OCCYSHN activities and projects, including CCN/practice teams, learning collaboratives, the LEND Family Mentorship Program, conference presentations and others. Families in the network represent a cross section of rural, urban and diverse socio-economic and ethnic families.
- Family Liaisons were added to CCN teams and practice teams. TenCCN teams have FLs, including two rural practices.
-Two temporary Family Staff were added to support growing FL participation on local teams and develop a training manual.
- Family Staff collaborated to increase family perspectives with the Office of Family Health, LEND Program, CDRC autism clinic, CDRC leadership committees, and the WSGSC:
*Family Staff participate in joint management meetings and selected committees with OFH, including ABCD Policy and Steering Committees, Region X conference calls and annual block grant review and leadership meeting, ECC Health Matters, and others.
*OCCYSHN family staff partnered with the autism clinic at CDRC to support and co-manage a parent consultant position. The parent consultant worked part time in the clinic to assist parents, make follow up phone calls, and track satisfaction. She was included in FIN meetings and activities.
*In partnership with the LEND training program, family staff coordinated the Family Mentorship Program, pairing LEND trainees with a Family Mentor, a family of a child or youth with special health care needs who mentored the trainee on practical realities of parenting a child with disabilities. Family staff served on the Training Coordinators Council, Curriculum and Leadership Committees and provided educational presentations about family centered care, systems of care, transition, and community resources.
*Family Staff participate in CDRC internal leadership committees, including Administrative Management, UCED Leadership, Search Committees, et al.
*In partnership with Family Voices and WSGSC, Family Staff assist in coordinating family input and involvement in the Western States Genetics Collaborative.
- Family Professional Partnership initiatives were highlighted at OR Rural Practice Research Network annual convocation, in plenary and poster sessions at OCCYSHN's annual conference, at Child Advocacy Night at OHSU, and NW Down Syndrome Assoc's conference.
- OCCYSHN staff participated in multiple family organization and coalition efforts, including local Developmental Disability Council, Special Olympics Oregon, Families and Communities Together (FACT), IEP Partners of the Oregon PTI and Family Voices.
- OCCYSHN worked with Oregon Family Voices and participated in Region X F V Leadership Training in 3/2008.
- Family staff assisted in developing a Family Centered Care Survey for CDRC clinics. It was used for quality improvement and tracking for the state legislature.
- The local PHNs and OCCYSHN nursing consultants provided information and decisional support to families in all counties through the CaCoon program. Families receive information about their child's condition, services and resources through consults and home visits.
- OCCYSHN continues disseminating information to families through its newsletter and website, WSGSC and through state and community based training events and resource fairs.
- OCCYSHN staff presented about Family Liaisons on Community and Practice teams at the AMCHP annual conference in 3/2008 and on Family Centered Care for Grand Rounds to CDRC staff.
- Staff works with the Family Action Coalition Team, the DD Council's Family Issues Committee, Oregon Health Action Campaign and Expanded Access Coalition to represent and support policy issues important to CYSHN and their families.
- OCCYSHN partners with Disability Compass to enhance its online database of resources for families of CYSHN.
- Block grant training and input session for families was initiated in 6/2008 for FL's as part of family involvement and public input.

- OCCYSHN and OIDD provided financial support to Partners in Policymaking for leadership training and translation services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families are on OCCYSHN staff and active partners on internal committees, activities and leadership.				X
2. Families are involved in community-based activities.				X
3. OCCYSHN staff partner with state agencies, organizations and family groups to provide family perspectives, identify issues and share information.				X
4. OCCYSHN partners with other areas of CDRC to promote family-centered care and family leadership.				X
5. OCCYSHN disseminates information and provides education to assist families in decision making.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Family staff work with local teams and Community Consultants. 3 teams lose FL due to work commitments or relocation; positions remain open. Practice teams complete initial work. Coos meets occasionally and Klamath Falls is no longer active. Lincoln Co team adds FL.
- Family staff is reduced by 0.50 at close with ending of Integrated Services grant. FLs sustained with OCCYSHN funds.
- FL Handbook and a FL recruitment packet is completed and disseminated.
- Continue emphasis on Family Professional Partnerships (FPP) as priority with OCCYSHN as well as with family organizations, coalitions, OFH, LEND, WSGSC, CDRC and OHSU. New linkages made with Oregon Lifespan Respite, American Association of Public Health Dentistry, Hands and Voices.
- Family staff and Oregon FV collaborated on family impacts of policy and legislative issues, including hearing aid bill, expanded coverage for children, and others.
- Family staff help coordinate training of LEND Family Discipline Trainee; serve as Family Faculty for seminars and training.
- Change of management for F2FHEIC changes level of engagement with project activities.
- Over 70 families currently part of Family Involvement Network with about 25 actively engaged in work.
- Family staff partner with WA F2FHEIC in training for family navigators.
- Community engagement in Klamath Falls targets family needs.

c. Plan for the Coming Year

- OCCYSHN will continue to support Family Liaisons on 9-10 CCN teams. Current Family staff will be reduced beginning July 1, 2009 to .5 FTE for one person due to changes in OCCYSHN budget.
- To the extent possible with reduced staff time, OCCYSHN will continue partnerships and collaborative activities with OHSU/CDRC partners including LEND and clinics, to assure family participation in decision-making, family-centered and culturally competent services and systems of care.
- OCCYSHN and Family Staff will work to ensure that family participation and input is included in the 5 year needs assessment.

- Family Staff will continue collaborative efforts with OFH around family partnership and inclusion in program and policy decisions.
- OCCYSHN will continue to support family leadership development and family education through partnerships with Family Voices and other family-driven organizations.
- OCCYSHN will pursue alternative methods of training and connecting families in FIN, including phone conferences and webinars. Initial training and orientation will be done with staff and Family Liaisons.
- OCCYSHN will pursue additional funding to support family professional partnerships and medical home activities. Family involvement will be included in grant submissions.
- OCCYSHN's website will be updated to include improved information for families, including Spanish language materials.
- Cultural competency and multicultural resources will be emphasized in community and state level activities as well as recruitment of Family Liaisons and any new family staff.
- Family staff, FIN members, and FV will work together to develop plain language materials to assist families in understanding and navigating systems of care.
- OCCYSHN will explore ways to expand and promote family involvement in decision making at the local level, including family participation in LICC's, family partnerships with CaCoon and county public health departments, and family involvement with managed care or other provider groups.
- OCCYSHN will work with Doernbecher Child Safety Clinic to highlight needs of CYSHN and obtain input from families for improvement of the Child Safety Clinic.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	60	53	53	53
Annual Indicator	52.3	52.3	52.3	47.4	47.4
Numerator	60337	60337	60337		
Denominator	115367	115367	115367		
Data Source					2005/06 NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	48	50	53	55	55

Notes - 2008
Nearly half of Oregon CSHCN (47.4 percent) received coordinated, ongoing comprehensive care within a medical home. This is nearly identical to the percentage of CSHCN nationally who were estimated to have received care in a medical home (47.1 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments
Note on data: Nearly half of Oregon CSHCN (47.4 percent) received coordinated, ongoing comprehensive care within a medical home. This is nearly identical to the percentage of CSHCN nationally who were estimated to have received care in a medical home (47.1 percent).

- Physician consult line was available to community providers, linking community providers with Developmental Pediatricians and other specialty care providers at OHSU.
- OCCYSHN staff participated with key state stakeholders on the ABCD Screening Academy to explore strategies for improving screening and reimbursement to providers, and referral to early intervention and treatment programs.
- Clarification of billing/reimbursement procedures through ABCD work was completed to increase practice of early and continuous screening. OCCYSHN disseminated best practices related to screening for young children through its own Screening Learning Collaborative (SLC) and other community based programs.
- Promoted developmental screening, linkage with primary care/early intervention/specialty care, and follow up services through activities of OCCYSHN. Three additional learning sessions brought five teams together to share results and learn from each other.
- SLC teams presented on their activities and findings at OCCYSHN's statewide conference.
- Providers throughout the state attended OCCYSHN's statewide conference that included presentations on Medical Home from a rural pediatrician; Partners in Care by family members, Autism Screening by a developmental pediatrician, and many other sessions on improving care and medical/nursing practice.
- OCCYSHN facilitated a meeting of 8 Community Pediatricians and 4 Developmental Pediatricians at its annual conference to address issues related to CYSHN.
- OCCYSHN sponsored Grand Rounds and follow up discussions with the Oregon Primary Care Association (OPCA) and Office of Rural Health related to Medical Home/Primary Care Home.
- OCCYSHN consulted with the OPCA, OHAC's Expanded Access Coalition, and the Oregon Rural Practice Research Network to identify strategies to improve medical home practice across the state.
- Participated in CDRC Grand Round presentations, LEND ID Forums on childhood disabilities and on health care coalitions to improve the health of CYSHN.
- OCCYSHN promoted the Disability Compass to pediatric and family practice physicians, nurse practitioners and family leaders to increase the level of awareness of resources for children and youth with disabilities. This web-based resource was promoted to families, other state and community partners through our newsletter, dissemination of promotional materials and our OCCYSHN website. Staff of Disability Compass provided interactive, hands-on demonstrations of the website and its capabilities at our 2008 training conference. This website supports linking families and providers with needed resources at the community level.
- Provided training for pediatric, primary care MDs and NPs on the importance/methods of early screening of children for developmental delay, emotional/behavioral problems and other health conditions.
- Continued to support public health nurse care coordination in every Oregon county through training and TA with local PHNs and LHDs via the CaCoon program. Connection with comprehensive primary care and care coordination are key aspects of CaCoon.
- OCCYSHN maintained the PHN/Care Coordinator web-portal designed to assist hospital discharge coordinators and PHNs to access state and local services and health care information for families, encouraging linkage between tertiary centers and community providers and resources.
- OCCYSHN sponsored/facilitated 14 CCN teams across the state. Most teams met monthly to provide interdisciplinary care, coordination, and problem solving for CYSHN and their families.

Training of local CCN team members, providers and families was sponsored 1-2 times per year in each CCN catchment area. CCN Consultants and partners worked with local hospitals to offer Grand Round CMEs on Autism Screening in rural communities. Sessions also included information on care coordination, referral to EI, and family resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Resources on chronic condition management through the OCCYSHN Web page			X	X
2. Educational programs focus on comprehensive care of chronic conditions			X	X
3. Promote effective communication between providers, consumers and programs				X
4. Public Health Nurses (CaCoon) and Community Connections Network (CCN) ensure families of CYSHN receive care coordination		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- OCCYSHN prepares information for the legislative session beginning Jan 2009, especially related to Primary Care/Medical Home, insurance and hearing aids for children.
- Updates added to OCCYSHN website related to current research and best practices on Medical Home as well as resource links.
- OCCYSHN explores ORCHIDS generated data to assess whether CYSHN served in public health programs have a Medical/Primary Care Home.
- OCCYSHN explores funding sources to expand activities related to Medical Home.
- OCCYSHN connects with key entities in the state working to improve access and quality of care for CYSHN, including OFH, OPCA, ONA, NWECI, OPS, FV and Oregon Health Access Campaign and others.
- Partnership with the LEND program continues, including planning for training and education about Autism Spectrum Disorders and appropriate care/Medical Home for children with ASDs.
- LEND partnerships include the Family Mentor Project, Curriculum Committee, and Training Coordinator Committee. OCCYSHN staff facilitated and helped plan several ID forums.
- CCN continues to provide a medical home for CYSHN and their families relative to receiving integrated community-based care. Family members continue to work on CCN teams as Family Liaisons. CCN teams across the state met approximately monthly to provide interdisciplinary team care coordination/problem solving for CYSHN.
- CaCoon nurses continue to be trained on promotion of medical home

c. Plan for the Coming Year

- OCCYSHN recognizes the centrality of the implementation of a medical home for CYSYHN. This next year, this performance measure will receive priority attention as we request assistance from HRSA to bring a robust training and TA activity to Oregon in partnership with the Oregon Pediatric Society and other care organizations to increase understanding of the concept and practices of medical home. OCCYSHN will disseminate current research and best practices on medical home to inform health care reform and interim of legislative session through Family Voices advocacy avenues and OPCA, OPS, Oregon Health Action Campaign.

- OCCYSHN will develop an OCCYSHN data book to inform health care reform and the interim legislative session around the needs of CYSHN and the importance of the medical home as conceived for CYSHN and their families.
- Utilize OCCYSHN data book in exploring funding sources which will expand activities related to care coordination, medical home, family professional partnerships and disparities in care.
- OCCYSHN staff will continue to work with health care professionals on education and partnerships including family perspectives and Family Professional Partnerships.
- OCCYSHN will continue to expand community development within the CCN program encouraging partnerships among family groups, provider groups, community groups and health collaboratives.
- OCCYSHN will work with the OHSU School of Nursing, School of Medicine and the OHSU clinics to encourage medical home principles including Family Professional Partnerships.
- OCCYSHN will continue to advocate for a medical home model which supports the needs of CYSHN through state policy work, partnerships and advocacy with local managed care groups.
- CaCoon Care Coordinators will partner at the local level with ENCCs in their managed care groups to ensure coordinated care.
- OCCYSHN will review and revise CaCoon program materials about its services. This brochure will be widely distributed to providers and the public.
- OCCYSHN will seek to identify and disseminate best practices being implemented at the local level demonstrating medical home in CYSHN in Oregon.
- OCCYSHN will explore partnerships with FQHC providers to inform them about CaCoon and CCN programs.
- OCCYSHN will participate in efforts to systematize identification and support to women experiencing maternal depression.
- OCCYSHN will work to increase access to mental health specialty consultation to pediatricians working with children mental health issues through partnership with the OPS Mental Health.
- OCCYSHN will sustain access to information and resources for families statewide to support their ability to secure the supports and services needed to care for their children.
- Oregon families of children with special health needs and providers will have access to information and referrals related to genetics and genetic services.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	57	58	56	56	62
Annual Indicator	55.7	55.7	55.7	61.5	61.5
Numerator	64259	64259	64259		
Denominator	115367	115367	115367		
Data Source					2005/06 NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	65	65	65	65

Notes - 2008
Almost two-thirds of families of CSHCN in Oregon indicated they have adequate public and/or private insurance to pay for needed services (61.5 percent). In comparison, the percentage of families indicating adequate public or private insurance was nearly identical (62.0 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments
Note on data: Almost two-thirds of families of CSHCN in Oregon indicated they have adequate public and/or private insurance to pay for needed services (61.5 percent). In comparison, the percentage of families indicating adequate public or private insurance was nearly identical (62.0 percent).

- OCCYSHN analyzed and tracked health reform concepts, activities, and legislation before the 2008 abbreviated pilot session. Families, partners, and policy makers were informed about proposed legislation and on impacts of emerging policy concepts on CYSHN. At end of brief session, OCCYSHN disseminated information on bills that passed.
- Continued interest by legislators and families around coverage for hearing aids for children led to information and data gathering from other states and professionals. Informational materials were developed by OCCYSHN and disseminated to partners, families, and policy-makers.
- CCN teams and CaCoon PHNs worked with uninsured families to enroll children in state programs, to receive c are through local physician practices, or to local Federally Qualified Health Centers.
- CCN teams and CaCoon PHNs provided care coordination and services to children and youth who were uninsured or underinsured
- OCCYSHN Nurse Consultants monitored data on insurance status of children and youth served by the CaCoon program. Data includes information of Medicaid, private coverage, and children without coverage.
- OCCYSHN Nurse Consultants provided information on managed care groups and training to local PHNs on strategies for obtaining approval for specialized requests for CYSHN, including equipment, medications and specialty evaluations.
- OCCYSHN staff and CaCoon Nurse Consultants linked with Exceptional Needs Care Coordinators. Information about ENCCs and their roles in Oregon Health Plan managed care organization was shared with local CaCoon PHNs and CCN teams.
- OCCYSHN sponsored lay health workers called promotoras through the CaCoon program in four areas of the state. Promotoras work primarily with Hispanic families with CYSHN to improve access to care and linkage with insurance and financial supports. Number of clients served are tracked through state data system.
- OCCYSHN contributed to development and implementation of ORCHIDS statewide data and tracking system. The system is used to track data and services provided to populations served by OCCYSHN and OFH.
- Tom Wolff and Associates provided a two-day training on coalition building for OCCYSHN staff, families, and partners. Principles were applied to coalition building efforts directed at increasing access to hearing and hearing aid insurance benefits.
- OCCYSHN responded to calls from families who had questions pertaining to SSI denial or approval letters. SSI provides OCCYSHN prepared letters to all families upon determination of eligibility that include reference to OCCYSHN and state resources. Staff provided information about OCCYSHN and instructions for contacting local SPD offices to make application for

Medicaid benefits.
- OCCYSHN partnered with Family Voices and Family-to-Family Health Education and Information Center around access to care and coverage for CYSHN.
- OCCYSHN staff collaborated with DMAP and the Oregon Health Services Commission to assure access to appropriate genetic services continued by promoting use of 1/1/07 guidelines outlining DMAP policy on payment for genetics evaluation, genetic counseling, and genetic testing. Information about DMAP genetics services coverage was posted on the Oregon Genetics Program web site www.oregongenetics.org, or, http://egov.oregon.gov/DHS/ph/genetics/index.shtml.
- Staff engaged in discussions with DMAP pertaining to Oregon Health Plan consumer protections for CYSHN.
- Analyzed data collected through Oregon's telemedicine initiative of the Western States Genetics Collaborative to compare costs and family satisfaction among real-time telemedicine, outreach clinics and travel to Portland clinics. Data will be used to advocate for cost effective coverage of genetic services.
- OCCYSHN participated in OFH's Early Childhood Comprehensive Planning Initiatives to increase outreach efforts related to insurance enrollment and maximizing understanding/use of insurance programs and benefits. The OCCYSHN Director participates in the Early Childhood Council.
- OCCYSHN continued financial supports to CDRC clinics to assure access to specialized care for CYSHN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate Family Support Program to address families' out-of-pocket expenses.		X		
2. Health care finance (HCF) education and advocacy activities.				X
3. Strengthen partnerships with families, providers, insurers, and legislators to address the concerns of HCF.				X
4. Provide financial support to tertiary clinics at CDRC and community based programs.		X		X
5. Partner with DMAP to address genetics services coverage on OHP.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
- OCCYSHN Family staff and OCCYSHN Director participate in multi-state technical assistance meeting with Catalyst Center and Bobby Peterson, Exec Director of ABC for Health, on ensuring families' access to full benefits of health insurance and system of care services.
- Collaboration with DMAP to assure access to appropriate genetic services continues. Preliminary data for 2007 about the use of genetic testing services by OHP enrollees is reviewed and DMAP is in the process of providing more detailed data.
- Participate in discussions with families, providers, policy makers and partners, including the Human Services Coalition of Oregon and the Expanded Access Coalition to identify, track and provide information on health care access and finance issues impacting CYSHN.
-OCCYSHN collaborates with OHSU government relations, professionals, organizations, and families on successfully passed legislation for hearing aid coverage in state regulated insurance plans.
-OCCYSHN continues to provide consultation and supports to CaCoon PHNs, CCN Teams,

families and others about financial hardship and impacts of insurance and coverage decisions.
-OCCYSHN sponsored training and consultation includes strategies to help families find and pay for needed services and supports.
-Funding for CDRC specialty clinics continues, but at a level 15% below prior year.
-CCN Toolbox, a web-based resource, is developed. Resources assist community providers and families find needed coverage and financial supports

c. Plan for the Coming Year

- Collaboration with DMAP and the Oregon Health Services Commission to assure access to appropriate genetic services will continue. The analysis of 2007 data about the use of genetic testing by DMAP enrollees will be completed and 2008 data will be obtained and analyzed. The need for reconvening a genetics advisory committee to these two agencies will be evaluated.
- OCCYSHN and its Family staff will compile or develop family training and informational materials related to maximizing health benefits and finding/using other financial resources.
- Training and materials for professionals and community providers will be developed or compiled to assist them in working with families to maximize benefits and find financial resources to assure that children and youth with special needs have the care and services they need.
- Training and consultation to community providers on CCN teams and CaCoon PHNs will continue to address insurance and access to community and financial resources that families need.
- Redesign of OCCYSHN program will continue supports to clinics and will also provide professional medical consultation to OCCYSHN community-based programs and local, especially rural, health care providers.
- OCCYSHN will request technical assistance from the Catalyst Center to assist in mapping assets at both the state and local level for insurance and financial resources needed by families to ameliorate financial hardship/bankruptcy. OCCYSHN will engage key local professionals and community-based teams in identifying and utilizing resources in their own catchment areas.
- OCCYSHN will work to develop stronger linkage with managed care plans and DMAP in order to track insurance denials, coverage limitations, as well as successful strategies for accessing services for CYSHN.
- OCCYSHN will seek additional data sources for tracking financial impacts related to inadequate coverage, denials, or other matters related to insurance and necessary supports for CYSHN.
- OCCYSHN will continue to track health reform efforts and initiatives within the state and nationally and disseminate information related to the impact for CYSHN.
- OCCYSHN will update website and CCN Toolbox with resources and strategies for maximizing health benefits, finding financial resources, and limiting financial hardship on families.
- OCCYSHN will work to assure access to specialty psychological services through improved OHP coverage.
- OCCYSHN will study the prevalence of unique issues related to the denial of services for genetic services for children with special health needs and their families.
- OCCYSHN will partner with Medicaid Quality Improvement to study usages of care coordination codes to support implementation of medical home for CYSHCN.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75	78	74	74	90
Annual Indicator	73.9	73.9	73.9	88.3	88.3
Numerator	85256	85256	85256		
Denominator	115367	115367	115367		

Data Source					2005/06 NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	92	92	92	92

Notes - 2008
Nearly 90 percent of families of CSHCN in Oregon (88.3 percent) and nationally (89.1 percent) reported that community-based systems are organized for ease of use.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments
Note on data: Nearly 90 percent of families of CSHCN in Oregon (88.3 percent) and nationally (89.1 percent) reported that community-based systems are organized for ease of use.

- OCCYSHN continued to fund the CaCoon program to provide care coordination of CYSHN and to assist families in accessing services. In FY08, 6527 services were delivered to 1834 families. CaCoon consultants provided training and orientation to CaCoon coordinators and to other PHNs who see CaCoon children.
- CaCoon funding supported PHN participation on Local Interagency Coordinating Councils to enhance community-based coordination across agencies serving young children. OCCYSHN participated on the State ICC to represent the issues of CYSHN.
- CCN teams provided assessments and care planning for 158 children. Local providers participating on the CCN teams continued to provide a range of unique services (n= 1386) addressing unresolved issues for CYSHN and to improve service capacity and awareness of issues related to serving CYSHN in their communities.
- OCCYSHN increased the number of Family Liaisons on CCN teams to 9 during FY08 to expand team expertise and identification of issues, needs, and barriers faced by families.
- OCCYSHN continued its partnership with the Disability Compass. This effort continued a query program and community contacts regarding the availability of key resources for families and providers.
- OCCYSHN continued to support a PHN liaison between tertiary care centers and communities to improve the continuum of care for discharged CYSHN. OCCYSHN maintained and updated its web-portal for discharge planners for CYSHN, to provide resources to assist in planning transition to community. Staff provided information about community services to a variety of care management professionals, and about tertiary care centers to a variety of local providers.
- OCCYSHN, with HRSA TA support, sponsored "Rejuvenating and Sustaining your Collaborations/Partnerships/Coalitions" By Tom Wolff and Associates in partnership with CDRC. External agencies were invited to participate. The training focused on the sustainability of the

coalitions, their lifespan and evaluation of the efforts of such collaboratives.
- Varying models of CCN Teams were implemented in communities according to their needs. OCCYSHN is working to capture the various models and to evaluate them for their ability to increase systems building, community engagement, and skills of local providers.
- Two practice teams were formed in rural Oregon in which families participated with a local pediatric practice to design and implement a quality improvement project to benefit care for CYSHN and their families.
- OCCYSHN partnered with state leaders on the Early Childhood Consortium and development/implementation of a plan to increase health care access for young children.
- OCCYSHN continued to expand connections with families and family organizations statewide, including Family Voices, to improve community-based services and access to care; partnerships were formed with ORPTI, OFSN (Oregon Family Support Network), the ARC of Oregon to involve families in access to care issues.
- OCCYSHN collaborated to improve increase use of standardized developmental screening in 5 Oregon communities through the SLC project. OCCYSHN conducted two videoconferences and one webinar on how communities were implementing their new screening practices; disseminated information on the ABCD project, the availability of and how to refer children to CCN; made plans for continued contact and communication with team sites through key contact person. Webinar was rated as the most efficient and effective method of distance communication for the purpose of "meeting" and training.
- OCCYSHN staff are working with WSGSC on the analysis of the effectiveness & sustainability of delivery of genetic services through telemedicine.
- OCCYSHN participated in the ABCD project as member on the Steering Committee, providing support and facilitation to the Demonstration Task Force. OCCYSHN coordinated the implementation of the CAHMI designed evaluation plan of the demonstration sites to evaluate newly designed screening and EI referral practices.
- At the local level, the CaCoon program received featured attention in local county public health newsletters and local media. This past year the Clackamas county CaCoon program was featured for its positive impact on families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. OCCYSHN and family participation in state level program and policy planning groups to assure CYSHN priorities and cultural needs are addressed.				X
2. OCCYSHN/CaCoon provides care coordination, including hospital/clinic discharge to community.	X	X	X	X
3. CCN and local Family Liaisons work to identify local resources, fill service gaps, develop strategies to meet needs of CYSHN in local communities.	X	X		X
4. Identify/enhance resources about services and systems of care for families and providers (Oregon Clicks, Disability Compass, OCCYSHN Liner newsletter, Newborn Handbook).			X	X
5. WSGSC/OCCYSHN explore and pilot alternative service delivery methods including telemedicine.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Implement CaCoon program statewide and 14 Community Connections Teams.
- Implement program criteria for all program efforts via contracts and evaluation, to include family involvement, health disparities, cultural competency, and AT.
- Support development of an effective universal referral form.
- Expand activity with community and family groups. Physicians, schools and other providers work with families to explore community resources and to familiarize themselves and others with those resources.
- Continue to partner with Family-to-Family Health Information and Education Center/Family Voices. FIN staff work with FACT (Families and Communities Together) and local support brokerages on a multi-county resource fair for families and professionals.
- OCCYSHN continues with the ABCD project, providing coordination of evaluation of demonstration of newly designed screening and EI referral practices.
- Assess feasibility of learning collaborative addressing oral health for CYSHN, screening, or autism.
- Explore options to improve and sustain home visiting programs for CYSHN. Analyze data to identify needs/gaps in services for CYSHN as addressed by CaCoon.
- OCCYSHN continues partnership with key state leaders on the Early Childhood Council to increase health status of young children.
- Review QI procedures with each of its program components; performance standards and accountability will be increased to assure continued excellence in program performance.

c. Plan for the Coming Year

- Explore opportunities to engage with existing rural based health care collaboratives to increase health care access for CYSHN.
- Expand use of web technology to provide additional training and resources to CCN Teams, including a webinar on practice-level quality improvement.
- Expand use of web technology to provide training and information to CaCoon nurses statewide relative to EHDI, as an example.
- Formation of a statewide learning collaborative regarding behavioral health and development with a particular focus on children and youth on the autism spectrum. Discussion and exploration of resources and treatments will be the primary activity of this group.
- Continued updating of resources through the Disability Compass website.
- CDRC resources continue to be disseminated and available to Oregon physicians.
- Support development and expansion of medical home concept to include technical support and family involvement in those efforts.
- Implement comprehensive dissemination plan to increase access to information useful to families and providers about accessing and locating resources in their communities.
- Serve as a partner with an anticipated future ABCD effort addressing care coordination with DHS/OFH/DMAP. Evaluate the impact of CCN teams to improve community- based systems of care at the local level.
- Further development of the CCN Toolbox utility to include resources for quality improvement.
- Perform training and annual site visits for the CaCoon program to assure quality program implementation.
- Explore additional opportunities to engage rural communities to support strengthening of system of care for CYSHN in these areas.
- Explore options to improve and sustain care coordination programs for CYSHN in light of reduced county funding. ORCHIDS data system provides evaluation data to help assess needs/gaps in services for CYSHN.
- Evaluate strengths and weaknesses of alternative methods for enhancing operation of local CCN teams; increasing family participation; and exploring methods to improve OCCYSHN activities at the community-level.
- EHDI diagnostic centers will be informed/trained about genetic based conditions affecting hearing.
- OCCYSN will support the input into the EHDI NBASC around genetic related issues and

information.
- OCCYSHN will assure access to developmental pediatric specialty consultation within community-based CCN teams.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	10	6	6	45
Annual Indicator	5.8	5.8	5.8	43.7	43.7
Numerator	6691	6691	6691		
Denominator	115367	115367	115367		
Data Source					2005/06 NS-CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	48	48	48	48

Notes - 2008
Over 40 percent (43.7) of CSHCN youth in Oregon between the ages of 12 and 17 were estimated to have received services needed for transition to adulthood. National estimates for this performance measure indicate a similar percentage (41.2 percent).

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments
Note on data: Over 40 percent (43.7) of CSHCN youth in Oregon between the ages of 12 and 17 were estimated to have received services needed for transition to adulthood. National estimates for this performance measure indicate a similar percentage (41.2 percent).

- OCCYSHN continued support and funding for Youth Advisory Group (YAG) after initial grant funding ended.
- OCCYSHN staff participated in development of consortium of groups and agencies to support youth leadership in areas of health care transition, secondary education and employment. The

Emerging Leaders Northwest (ENLW) consortium met regularly as forum for youth to acquire and support self determination and leadership skills.
- A young adult leader from the YAG was hired as the group's Coordinator. OCCYSHN staff mentored the Coordinator in planning meetings and maintaining youth activities, including goal setting, health care transition, healthy lifestyles, employment and independent living. Connection with Coordinator and youth was maintained through regular meetings, e-mail and a group listserv.
- Transition priorities as defined by YAG and ELNW members were shared with providers and others. Youth presented on AT at LEND student training session.
- Information on AT was disseminated at OCCYSHN annual conference, through LEND seminars presented by OCCYSHN staff, on ELNW website, and with patient care teams at Shriners Hospital for Children, and Building Futures conference sponsored by Oregon PTI.
- OCCYSH staff worked collaboratively with CDRC on a curriculum for a week-long camp for youth in transition called "Dream It Do it".
- CCN teams across the state developed local partnerships around AT, increased attention toward AT issues and care coordination.
- OCCYSHN began exploration of opportunities to continue or enhance AT efforts and activities, including searching for additional sources of funding and partnership.
- In conjunction with OIDD, OCCYSHN sponsored youth attendance and presentations by YAG at the "Celebrate Wellness" conference.
- Staff participated in conference calls and technical assistance with Healthy and Ready to Work.
- OCCYSHN website was updated to include links with partner agencies, national resources on AT and web-streamed training events at www.occyshn.org.
- OCCYSHN promoted contribution and use of AT resources to Disability Compass website.
- OCCYSHN PHN staff updated CaCoon manual with comprehensive information on AT, including tools that local PHNs can share with families and professionals.
- County public health programs that participated in AT grant funded activities were monitored after completion of grant for number of youth served and sustained attention to AT concerns.
- OCCYSHN partnered with Family Voices to include youth perspective in Region X Family Voices Meeting.
- OCCYSHN supported OIDD/CDRC summer youth employment experience and provided working experience in OCCYSHN office.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate information and strategies for successful youth transition.		X	X	
2. Support Youth Advisory Group, CaCoon nurses and Community Connections Network (CCN) teams in addressing transition needs throughout the life cycle.				X
3. Partner with communities, families, schools and providers in addressing Adolescent Transition (AT) health care concerns.				X
4. Promote AT issues and Youth Involvement within program, agency and policy arenas.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
- OCCYSHN continues partnerships with ODE, Shriners Hospital staff, CDRC clinics, Addictions and Mental Health Services, OrPTI, Family Voices, and others to address issues related to

transition.
- YAG group continues to meet quarterly. Members share goals and support members to achieve goals. Meetings included discussion and skill building re: Job Development, Working with Providers, and Personal Health and Wellness.
- OCCYSHN is a participating member of ELNW consortium. Health care transition is included in curriculum.
- YAG Coordinator receives scholarship to AMCHP, participates in AMCHP annual meeting, shares experiences with youth.
- YAG and ELNW member presents "Become a Director of Your Own Life" at 2009 Administration on Developmental Disabilities Youth Information, Training and Resource Center's Technical Assistance Institute.
- OCCYSHN staff and YAG members present sessions on AT for LEND students.
- YAG and ELNW work toward integration for sustained AT activity. A few YAG members participate as ELNW members; one YAG member becomes an employee of CDRC.
- Connections with state groups, including Oregon Association of Vocational Special Needs Personnel, UCP, supports attention to AT issues.
- YAG and ELNW youth participate in "Dream It Do It" camp both as participants and leaders.
- OCCYSHN sustains emphasis on AT through CCN teams and CaCoon PHNs.
- OCCYSHN conducts survey of services to adolescents by local CaCoon PHNs.

c. Plan for the Coming Year
- Due to funding changes in OCCYSHN budget, YAG will not continue to meet.
- OCCYSHN will continue to explore opportunities to engage youth and provide training on AT. New capability with technology and distance learning will be included, such as Adobe Connect webinars, You Tube, Facebook.
- Work through existing partnerships along with potentially new connections with Outside In, KASA, and the Independent Living Centers, will be explored as venues to continue youth engagement.
- OCCYSHN will work through CCN and CaCoon to connect with School Based Health Centers and Educational Service Districts to address AT issues and provide best practice information related to CYSHN.
- OCCYSHN will update website and develop AT resources for CCN Toolbox to support education and dissemination of materials.
- OCCYSHN will continue to provide in kind support through staff participation in ELNW and Dream It Do It activities.
- OCCYSHN, OIDD, LEND, and other CDRC or OHSU entities will meet and work toward sustaining youth involvement and AT emphases, including seeking funding and opportunities for shared activity or training.
- OCCYSHN will pursue joint efforts with OFH staff addressing Adolescent Health and also with CDRC's Research and Training Center for Health and Wellness.
- OCCYSHN will include family and youth perspectives on health care and AT in planning and implementing 5 year needs assessment.
- OCCYSHN will analyze survey results of adolescent transition services provided by local CaCoon PHNs and disseminate results of study.
- OCCYSHN nurse consultants will continue to provide TA to CaCoon nurses on AT.
- Adolescent transition will receive targeted efforts within the context of its community-based programs through increased monitoring of youth receiving services, training and consultation.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	79	79	80	75	79
Annual Indicator	78.5	72	78.4	72.4	72.4
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79	80	80	80	80

Notes - 2008
The percent of Oregon two year olds receiving all recommended immunizations has remained stagnant over the past four years. While Oregon is not expected to meet the Healthy People 2010 national series objective of 80%, Oregon is on track to meet the 90% Healthy People 2010 goals for Polio, Measles, Mumps and Rubella, Haemophilus influenza, and Hepatitis B. 2008 data not available.

Notes - 2007
Target for 2007 should be changed to 79.0%

Notes - 2006
Source: National Immunization Survey
Target for 2006 should be changed to 79.0%

Rates for 2004 should changed to 78.9% and 72.9% for 2005.

a. Last Year's Accomplishments
Note on data: The percent of Oregon two year olds receiving all recommended immunizations has remained stagnant over the past four years. While Oregon is not expected to meet the Healthy People 2010 national series objective of 80%, Oregon is on track to meet the 90% Healthy People 2010 goals for Polio, Measles, Mumps and Rubella, Haemophilus influenza, and Hepatitis B. 2008 data not available.

- In 2008, 840,206 doses of vaccine valued at $27,967,477 were shipped to public and private providers statewide.

- Several thousand health care and school professionals use Oregon's two Immunization Information Systems (IIS) -- ALERT the statewide registry and IRIS the public-sector electronic record. Both have a direct impact on Oregon's ability to improve immunization practices and avoid costly duplicate doses.

- ALERT sends monthly recall reports to over 350 Oregon clinics for two-year-old children who are overdue for shots. Oregon's Immunization Program uses ALERT data to create comprehensive reports about immunization practices for private and public clinics, and immunization quality improvement measures.

- Recall postcards are sent to children statewide who are not up-to-date on immunizations from ALERT and IRIS data systems.

- The Oregon Immunization Program provided Immunization Practice Assessments (AFIX - Assessment, Feedback, Incentives, and eXchange) to every Medicaid-contracting health plan with a report detailing the immunization coverage rates of their two year-olds. A project between DMAP and Medicaid began to implement quality improvement strategies focused on increasing immunization rates for two year olds. Interventions are focused on assessment of immunization rates by plan and recalls for past-due members.

- Hospitals statewide had access to state-supplied hepatitis B vaccine for all newborns. Local health departments partnered with the Immunization Program to enroll hospitals in this new program.

- Oregon Partnership to Immunize Children (OPIC) and Immunization Program co-hosted two Roundtable meetings in fall 2008 that focused on parent vaccine hesitancy and vaccine management. These meetings were well attended and received high evaluation marks.

- Developed immunization rates for counties that are population-based and client-based to support the program efforts in DMAP, Babies First home visiting, and WIC who assist in improving immunization series completion. Rates can be found at http://www.oregon.gov/DHS/ph/imm/Research/index.shtml

- Public health nurses screened, educated, and administered immunizations through the Babies First and CaCoon home visitation program. They also advocated for adequate community immunization coverage in various multi-agency community meetings.

- To improve efficiency and outcomes of data systems for surveillance, monitoring, and management of immunizations and vaccines, the Immunization Program selected a system that will integrate the statewide registry (ALERT) and the public provider tracking systems (IRIS).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. School immunization laws in place to assure all children in children's facilities are up-to-date annually			X	X
2. Vaccines for Children and the 317 Programs provide vaccines for eligible populations		X		
3. Outreach about immunization disseminated through training, consultation, and health education				X
4. Immunization information systems (IIS) track immunization status and recall individuals				X
5. AFIX assessment for public and private providers monitors clinic rates and identifies gaps and needs for providers		X		X
6. WIC screens and refers any participants aged 3-24 months for immunizations		X		X
7. WIC and Immunization programs collaborate and coordinate services at the state and local levels				X
8. FamilyNet client data system links immunization and WIC client data				X
9. County-specific immunization rates produced annually and shared with local partners to improve targeting of population-			X	

based strategies				
10.				

b. Current Activities

- The OPIC Health Disparities Workgroup is leading development of statewide partnerships and measures to monitor and respond to changes in access to immunizations during the economic downturn.

Immunization Program is:

Producing and disseminating 2008 population-based immunization rates by ethnicity, race, county of residence, WIC enrollment, Babies First enrollment, and DMAP enrollment for use by DHS, local health departments and community partners.

Continuing AFIX activities to improve immunization coverage rates across the state with healthcare providers and health systems continue.

Coordinating with tribal clinic partners to provide technical support and to assure that all American Indian and Alaskan Native children have access to recommended immunizations.

Continuing annual funding through performance-based contracts to thirty-four LHDs supports their direct and population-based services to communities.

- The Immunization Policy Advisory Team (IPAT), Oregon Partnership to Immunize Children (OPIC), and DHS are working in partnership to address systemic barriers in vaccine financing.

- ALERT data accuracy and completion is being improved to ensure providers can accurately forecast children's immunization needs.

- ALERT data exchange will be augmented with electronic medical record systems to ensure that complete and up-to-date childhood immunization records are available to providers.

c. Plan for the Coming Year

- Provider education will continue to promote the Vaccines for Children (VFC) program to eligible populations, the need for reasonable administration fees, and appropriate client billing.

- VFC will offer technical assistance and consultation to support partnerships between public and private immunization providers.
- Population-based immunization rates by county and partner program status for 2009 will be produced and shared with local partners.

- The Immunization Program will launch a statewide social marketing campaign to reach vaccine-hesitant parents.

- Collaborate with Public Health nurses, through the Babies First and CaCoon home visitation program, to identify best practices to improve immunizations for their populations. May include access to the ALERT registry data on immunizations for their clients to assure that appropriate recommendations are made.

- Plans include implementation of the new Immunization Information System that will combine ALERT and IRIS registries.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	17	16	15.5	15	15
Annual Indicator	15.6	15.8	17.7	16.6	17.5
Numerator	1117	1151	1303	1228	1314
Denominator	71614	72821	73444	73997	75054
Data Source					Or. Ctr Health Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	16	15	14	13.5

Notes - 2008
Numerator: Oregon Center for Health Statistics
Denominator: Population Research Center
The birth rate for teenagers (15-17) trended upwards between 2004 (15.6) to 2006 (17.7). The three year average from 2006 to 2008 shows a slight reduction to 17.3 per 1,000 teens, from the high of 17.7 in the single year 2006.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics, 2006

a. Last Year's Accomplishments
Note on Data: The birth rate for teenagers (15-17) trended upwards between 2004 (15.6) to 2006 (17.7). The three year average from 2006 to 2008 shows a slight reduction to 17.3 per 1,000 teens, from the high of 17.7 in the single year 2006.

- The Adolescent Health Section (AHS) moved towards a more holistic approach in addressing adolescent sexuality by revising the former Teen Pregnancy Prevention Coordinator position to be the Adolescent Sexual Health Program Coordinator position. This shift recognizes that sexual health encompasses more than pregnancy prevention. It includes preventing not only pregnancy but sexually transmitted infections and sexual and relationship violence. The shift also recognizes that sexuality is a normal part of human development, and that youth have the right to education and information that allows them to make healthy decisions.

- The Oregon teen pregnancy prevention (TPP) program is a partnership between Title V and TANF, led by the Department of Human Services Children, Adults, and Family Division (CAF) with co-leadership by the Office of Family Health. Both agencies serve on the Teen Pregnancy Prevention and Sexual Health Partnership (TPP/SHP), which was formalized in 2005. Membership includes: Oregon Department of Education, Oregon Commission for Children and Families, Family Planning Services, HIV/STD Prevention, Planned Parenthood Affiliates, Cascade AIDS Project, three local health departments and the Oregon Teen Pregnancy Task Force (OTPTF), a non-profit group that has been in existence for 29 years. The Partnership meets monthly to assess and evaluate statewide teen pregnancy prevention work, including

support of the Oregon Youth Sexual Health Plan, providing leadership for its implementation and developing ongoing policy recommendations.

- In 2008, TPP/SHP completed the final editing of the Oregon Youth Sexual Health Plan. The plan incorporates Positive Youth Development principles and a strong youth voice, and includes: literature reviews, new survey/data collection, analysis of state & local-level surveillance data, input from nine regional community forums, and Youth Action Research.

- In April 2008, The Adolescent Sexuality Conference was held in Seaside Oregon. Approximately 300 youth service providers and youth attended sessions on pregnancy prevention, STI prevention, healthy relationship promotion and ways to outreach to youth.

- In April 2008, the Rational Enquirer was distributed at the Adolescent Sexuality Conference and via direct mail to 3,000 Oregonians. Distribution includes adolescent pregnancy prevention agencies, lead staff, teen leaders and health educators. The Rational Enquirer, a youth-focused magazine addressing sexual health, is an annual publication of the Oregon Teen Pregnancy Task Force in collaboration with Office of Family Health.

- Oregon's abstinence education program, STARS (Students Today Aren't Ready for Sex), is managed by Children, Adults and Families Division. It is the primary abstinence education program in the state. STARS is based on the PSI (Postponing Sexual Involvement) curriculum and utilizes a peer leader model. The Adolescent Sexual Health Program Coordinator worked with STARS program staff to create an abstinence-based curriculum that adheres to the principles of comprehensive sexuality education. The enhanced curriculum was made available to all STARS programs in the fall of 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with other agencies to implement teen pregnancy prevention strategies				X
2. Provide technical assistance to county health departments and other organizations working toward teen pregnancy prevention goals				X
3. Implement, support and coordinate actions to meet objectives of the Oregon Youth Sexual Health Plan			X	
4. Teen pregnancy prevention media campaign raises awareness of adolescents, parents and other adults.				X
5. Collaborations with schools and other programs, such as Coordinated School Health				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- The Adolescent Sexual Health (ASH) Program Coordinator worked in collaboration with TPP/SHP partners to release the Oregon Youth Sexual Health Plan statewide. In April 2009, all County Health Departments received the Plan and School-Based Health Care Coordinators participated in a Webinar on the Plan.

- In February 2009, The ASH Program Coordinator worked with the Department of Education to

submit a proposal for the Grove & Packard Foundations "Working to Institutionalize Comprehensive Sexuality Education" grant.

- The AHS provided funds for and developed a strategic planning workshop for the Oregon Teen Pregnancy Task Force (OTPTF) in February 2009 and continues to work with OTPTF to strengthen its statewide work.

- In April 2009, a new edition of the Rational Enquirer was released.

- The AHS provided funding and staff support for the April 2009 Adolescent Sexuality Conference, attended by approximately 275 youth and youth service providers.
- The ASH Program Coordinator:
  - Provides on-site technical assistance to health departments and community-based organizations to integrate adolescent sexual health services across the state on an on-going basis,
  - Is leading a process with TPP/SHP partners to formalize the group's purpose and role,
  - Is working in an advisory role with Portland State University and Multnomah County Health Department to develop an evaluation of a teen pregnancy prevention project in the Latino community.

c. Plan for the Coming Year

- The Adolescent Sexual Health program will continue to provide support and technical assistance in implementation of the Oregon Youth Sexual Health Plan. The Adolescent Sexual Health Program Coordinator will review local public health agency's priorities and needs around teen pregnancy prevention. Information from that review will be used to develop a training activity for local public health agencies.

- The Adolescent Sexuality Conference will be held in April 2010 at Seaside, Oregon.

- The Adolescent Sexual Health Program Coordinator will gather feedback via focus-groups on the usefulness and value of the Rational Enquirer. Based on feedback and with input of the Oregon Teen Pregnancy Task Force, a new publication schedule may be created. The focus-group feedback will be incorporated into the next issue.

- The ASH Program Coordinator will continue to take a leadership role in the Teen Pregnancy Prevention - Sexual Health Partnership.

- The Adolescent Health Section will continue to closely monitor teen pregnancy and birth rates. Teen pregnancy and birth rate increased from 2005 to 2006, decreased in 2007.

- The Adolescent Health Section Manager will serve on the Association of Maternal and Child Health Programs Reproductive Health Disparities Advisory Board to help guide their capacity building efforts for Title V grantees.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	55	55	55	52	52

Annual Indicator	50.0	50.0	42.0	42.7	42.7
Numerator	650	650	546	1261	1261
Denominator	1301	1301	1301	2953	2953
Data Source					Oregon Smile Survey, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44	44	50	52	55

Notes - 2008
Data for this measure is available only every five years through the Oregon Smile Survey. 2007 data are carried forward for 2008.
The two data points available (2002 and 2007) are similar to one another (42% and 43% respectively) and indicate that little progress has been made on this measure. Both percents are below the Healthy People 2010 goal of 50%.

Notes - 2007
Source: Oregon Smile Survey, 2007.

Notes - 2006
The next anticipated dateData source is the Oregon Smile Survey, last performed in 2000. Numerator and denominator is carried forward for each year. The next Smile Survey is scheduled for 2006/2007, and results will be available late 2007.

The correct percentage for 2004-2006 is 42%

a. Last Year's Accomplishments
Note about the data: The survey for this measure is available every five years through the Oregon Smile Survey. 2007 data are carried forward for 2008. The two data points available (2002 and 2007) are similar to one another (42% and 43% respectively) and indicate that little progress has been made on this measure. Both percents are below the Healthy People 2010 goal of 50%.

- The Oral Health Program increased the number of schools participating in the school-based dental sealant program from eleven in school year 2006-07 to over forty in the 2007-08 school year. Over 1800 children were served and over 5600 dental sealants were placed in the 2007-08 school year.

- A full-time School Programs Coordinator was hired to support the dental sealants program.

- A total of twelve portable dental sealant units were purchased and distributed to sites across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Community-based and school-linked partnerships are supported through statewide technical assistance from the Oral Health Program				X
2. Smile Survey provides assessment data to monitor status of sealants			X	
3. Dental sealant promotion campaign to raise awareness of the benefits of sealants			X	
4. Statewide sealant program partnering with schools			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- The Oral Health Program is operating the dental sealant programs in over sixty schools. An estimated total of 11,000 sealants will be placed in children aged six through eight.

- The Oral Health Program was able to leverage state general funds that support the school-based dental sealant program to expand the program to recruit more volunteers and provide the services to more schools.

- The Oral Health Program will be conducting a feasibility study on incorporating a retention check component into the school-based dental sealant program.

- The Oral Health Program is piloting a project that is testing the feasibility of collecting insurance information on the parental permission forms and subsequently billing the Oregon Health Plan or third party payer. A final report is due in September 2009.

c. Plan for the Coming Year

- Schools participating in the dental sealant program in the previous year will continue to participate. Over 100 schools are targeted for the 2009-10. Since overall oral health status is dependent on numerous factors it is impossible to project the impact that the school-based dental sealant program will have on dental sealant rates when the next Smile Survey is conducted in 2012. However, some impact is expected as our program targets first and second graders and we anticipate being able to provide more sealants before decay sets in. Previously, our program targeted second and third graders. Preliminary data from the SEALS data analysis program indicates that we are able to seal a higher rate of teeth and have far less children unable to receive sealants due to un-erupted teeth than was initially predicted.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.6	3.4	3.2	2.8	2.8
Annual Indicator	3.6	3.0	3.3	3.3	3.3
Numerator	26	21	23	23	23

Denominator	729110	699202	702864	702864	702864
Data Source					CDC-Injury Query and Reporting System 2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3	2.7	2.7	2.5

Notes - 2008
The most recent data for this measure (2006) indicates a rate of 3.3 deaths per 100,000 children 14 years and younger. This rate is comparable to the rates for 2004 (3.6) and 2005 (3.0). 2006 data from CDC Web-based Injury Statistics Query and Reporting System is carried over for 2007 and 2008.

Notes - 2007
Source: Oregon Center for Health Statistics. Death data for 2006 and 2007 not available as of July 1, 2008.

2005 data is repeated for 2006 and 2007 for purposes of TVIS reporting.

Notes - 2006
Death statistic data for 2006 and 2007 not available as of July 1, 2008.

2005 data is repeated for 2006 and 2007 for purposes of TVIS reporting.

a. Last Year's Accomplishments
Note on the data: The most recent data for this measure (2006) indicates a rate of 3.3 deaths per 100,000 children 14 years and younger. This rate is comparable to the rates for 2004 (3.6) and 2005 (3.0). 2006 data from CDC Web-based Injury Statistics Query and Reporting System is carried over for 2007 and 2008.

- Safe Kids Oregon completed a statewide needs assessment to identify the most significant childhood injury incidences and risks statewide. Data was used to create a 3-year strategic plan to reduce childhood injuries statewide. The same data set was used to conduct a needs assessment on injury issues for each of the fourteen (14) local Safe Kids coalitions throughout the state.

- Nurse Consultants in the Office of Family Health (Title V Office) partnered with the Child Injury Prevention Program (located in the Injury Prevention Section, Office of Disease Prevention and Epidemiology (ODPE) in the Public Health Division) to assure that local MCH nurses continue to have education opportunities and up-to-date information regarding child car seat safety. A Nurse Consultant serves as a member of the State Child Fatality Review Team.

- Child Injury Prevention Program (CIPP) provided a county-by-county estimate of the number of child safety and booster seats needed to fully meet current and 5-year projected demands (based on current poverty rates among children). This data assisted county health departments, and

other agencies serving low-income children, to understand countywide demand and need for child restraints, and the need for collaborative efforts to meet this need. CIPP and other statewide partners assisted counties in funding, training, and capacity building.

- Two statewide injury prevention trainings were held; one in conjunction with the Lifesavers Conference in April, 2008; and one in conjunction with the Oregon Transportation Safety Conference in October, 2008.

- CIPP/Safe Kids Oregon and partners attended the national Lifesavers Conference on motor vehicle safety in Portland in April. Additionally, the Oregon Safe Kids program director presented results of the child safety seat evaluation during one session at Lifesavers.

- Safe Kids Oregon assisted three local chapters achieve coalition status as of July 1, 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Child Injury Prevention Program and Safe Kids Oregon, supported by Title V, promotes motor vehicle safety for children. Safe Kids Oregon is the state office of the national Safe Kids.			X	X
2. Car seat safety promotion occurs through state and local media, local safety events			X	
3. Oregon Safe Kids provides support and technical assistance in the development of local coalitions				X
4. Public Health Nurse home visiting programs provide anticipatory guidance and health education to parents about car seats		X	X	
5. Training for certified safety seat technicians occurs throughout the state		X		
6. Safety seat inspections by local certified technicians assures correct use of seats		X		
7. Statewide needs assessments for child safety seats provides information for programs				X
8.				
9.				
10.				

b. Current Activities

- Safe Kids Oregon is assisting two chapters (Columbia Gorge and Central Oregon) in capacity building to move into coalition status, and develop one new chapter in Klamath County.
- The Child Injury Prevention Program/Safe Kids Oregon is collaborating with the Child Safety Seat Resource Center to identify counties in need of nationally certified Child Passenger Safety (CPS) Technicians, based on a 2007 evaluation project. CPS Technicians are identified throughout the state to provide a senior leadership role at local child safety seat clinics.
- The Child Injury Prevention Program/Safe Kids Oregon has developed a single child passenger safety clinic reporting tool and provided training on the tool statewide. The tool, combined with scanned forms, will provide data to complete a statewide child passenger safety report on numbers of families served at local car seat clinics; the numbers of child safety seats that were distributed statewide; and the correct installation data for improvement processes.
- The CIPP/OSK program will provide one statewide training opportunity in October in conjunction with the Transportation Safety Conference, and provide two workshops in the Portland area. Scholarships will be provided to help Safe Kids coalition coordinators attend the statewide conference.

- The CIPP/OSK program produced its first annual Safe Kids injury report to establish baseline indicators in each coalition throughout the state.

c. Plan for the Coming Year

- Safe Kids Oregon will assist one chapter (Lane County) to achieve coalition status in 2010. With the addition of Lane County moving from a chapter to a coalition, this brings a total of 1 state office (supported by Title V), 8 coalitions, and 7 chapters in Oregon, geographically representing over 85% of the state's children ages 0-14.

- The CIPP/Safe Kids Oregon program will provide a follow-up evaluation report to a 2007 study that identified where need was greatest for child safety seats statewide. This evaluation will determine whether low-income families received the services needed and a cost benefit analysis of 3 years of funding and training to reach these families.

- CIPP/Safe Kids Oregon will increase injury prevention safety information to the public by utilizing a website blog. The same site will provide access to documents and reports needed by local coordinators, including local data on child passenger safety efforts.

- CIPP/Safe Kids Oregon will provide additional technical support to Safe Kids chapters and coalitions statewide in sustaining local child passenger safety efforts during a recessed economy.

- The Safe Kids Advisory Board will develop a fund raising plan to raise funds to support infrastructure of both the state office and local coalitions. Additionally, at least one fund raising project will be implemented.

- The CIPP/OSK program will provide one statewide training opportunity, two workshops in the Portland area, and one web-based training program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			55	58	60
Annual Indicator		53	56.4	62.1	62.1
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	63	64	64	65

Notes - 2008
The most recent data for this measure indicates that 62.1% of Oregon women breastfed their infants at 6 months in 2005, the highest percentage of any state and a slight increase over the 2004 percent (59.6). Both numbers are substantially higher than the Healthy People 2010 objective of 50%. Updated with correct data from National Immunization Survey, new data from NIS not avilable until late 2009.

Updated data (2008 Report)

2004 = 59.6%
2005 = 62.1%
2006 = 62.1%

Note on 2006 Note: the data in this note is no longer up to date.

Notes - 2007
Source: National Immunization Data, CDC. Table 2, Geographic-specific Breastfeeding Rates among Children. Correct trends are:
2004= 59.6%
2005= 62.1%
2006= 62.1%

Notes - 2006
Source: National Immunization Data, CDC. Table 2, Geographic-specific Breastfeeding Rates among Children. Correct trends are:

2000 = 54.3%
2001 = 57.5%
2002 = 47.9%
2003 = 62.3%
2004 56.4%
Data from 2004 also known as 2006 respondents - mothers of babies age 19-35 months old.

NIS does not provide a numerator and denominator.

a. Last Year's Accomplishments
Note on the data: The most recent data for this measure indicates that 62.1% of Oregon women breastfed their infants at 6 months in 2005, the highest percentage of any state and a slight increase over the 2004 percent (59.6). Both numbers are substantially higher than the Healthy People 2010 objective of 50%.

- Oregon continues to have among the highest breastfeeding initiation rates in the country. The CDC Breastfeeding Report Card demonstrates that Oregon exceeds the national average for all indicators. (http://www.cdc.gov/breastfeeding/data/report_card2.htm)
- The cross-office Breastfeeding "Think Tank" in the Title V agency, Office of Family Health (OFH), continued innovative activities such as promoting the Breastfeeding-Friendly Employer project and creating a resource on the internet (http://www.oregon.gov/DHS/ph/bf/working.shtml); providing breast-feeding information in the Newborn Handbook (distributed to mothers in hospitals; tracking breastfeeding experiences through the statewide SafeNet hotline; and participating in World Breastfeeding Week. There has been continued dialogue with the Department of Medical Assistance Programs (DMAP -- Oregon's Medicaid Agency) to assess lactation services and care offered through their contractor programs.

- The law relating to expression of breast milk at work (House Bill 2372, ORS 653.077) was passed in 2007 and went into effect January 1, 2008. This law is now the strongest in the country guaranteeing workplace accommodation for breastfeeding mothers. The law applies to pumping breast milk, addresses time and space needs and provides a remedy for non-compliance. It covers 70% of the Oregon workforce and applies to full and part time workers. Partnership with the Bureau of Labor and Industries has occurred in order to implement the law.
- OFH continued to promote Senate Bill 744 (1999 with Executive Order) which affirms a women's right to breastfeed in public. Cards explaining the law were printed in English and Spanish, and distributed to hospitals, employers and the public.
- WIC continued to promote and support a breastfeeding pump project. Pumps are provided to WIC participants through funding provided by the USDA and WIC provider training includes a breastfeeding training module. Additionally, Oregon WIC program implemented the research project that will include breastfeeding peer counselor program in WIC services and provide advanced breastfeeding training for local WIC staff.
- TANF (Temporary Assistance for Needy Families) / WIC partnership continues to support working breastfeeding mothers, the only collaboration of its kind in the nation. TANF implemented a new breastfeeding policy that assures mothers are encouraged to breastfeed and are referred for services especially WIC. All TANF staff statewide are trained on the importance of breastfeeding and the new policy. WIC developed a brochure specifically for TANF clients.
- OFH Nutrition Consultant staff are involved with The Breastfeeding Coalition of Oregon. (http://www.breastfeedingor.org/) and participated in the second annual meeting in Spring 2008.
- Breastfeeding support guidelines were added to the statewide emergency preparedness plans.
- Public health nurses provide anticipatory guidance, health education, assessment and support for parents after birth to assure and support optimal nutrition through breastfeeding for clients enrolled in Maternity Case Management and Babies First.
- OFH is continuing efforts to improve data quality from breastfeeding surveillance by monitoring NIS data, PRAMS data, and WIC data to determine breastfeeding initiation, duration, and exclusivity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assessment development activities include PRAMS questions and links with newborn screening data				X
2. Breastfeeding-Friendly Employer project assures mothers have opportunities to breastfeed at work			X	
3. Governor's Executive Order in 1999 requires all state agencies have location for breastfeeding		X		X
4. Education and technical assistance provided through the Newborn Handbook distribution to all pregnant women and new mothers				X
5. WIC, Perinatal, and home visiting programs provide information & support to all pregnant women about benefits of breastfeeding	X	X	X	
6. WIC provides information and support for lactation, referrals to community organizations	X	X		
7. Coordinate with & support Breastfeeding Coalition of Oregon			X	X
8. Coordinate with key partners to update policy to promote breastfeeding support activities.			X	X
9. Breast milk expression at work law (House Bill 2372)			X	X
10. TANF/WIC collaboration supporting working mothers		X	X	

b. Current Activities

MCH Nutrition Consultants will:
- Continue implementation of the breast milk expression and return to work law (HB 2372) in partnership with the Bureau of Labor and Industries, and the Breastfeeding Coalition in promoting HRSA's "The Business Case for Breastfeeding" model for improving worksite awareness and support for breastfeeding.

- Continue dialogue with DMAP about coverage for lactation care and services through Oregon Health Plan programs.

- Proceed with implementation of the TANF project that began in 2008.

- Breastfeeding projects in WIC will continue implementation and evaluation.

c. Plan for the Coming Year
- The Breastfeeding "Think Tank" of the Office of Family health will continue work on improving breastfeeding initiation and duration rates by implementing activities that raise awareness and provide breastfeeding education.

- To implement HB 2372, breastfeeding support pieces will continue to be distributed and promoted using HRSA's "Business Case for Breastfeeding" and "Oregon's Breastfeeding Friendly Employer Project."

- The WIC breastfeeding pump project, peer counselor demonstration/research project, Gold Ribbon Campaign Fathers Supporting Breastfeeding, sponsorship of the La Leche League conference, and advanced breastfeeding training will continue through 2010.

- MCH Nutrition Consultants will continue implementation of project recommendations of TANF population.

- Assessment, planning, and implementation of supporting breastfeeding in DMAP programs, perinatal regulations, and emergency preparedness will continue to develop.

-Oregon will participate in the World Breastfeeding Week by providing promotional materials to local health departments and WIC providers. An annual list of breastfeeding-friendly employers will be published during World Breastfeeding Week.

- OFH will continue to partner with the Breastfeeding Coalition of Oregon, and Nursing Mother's Counsel.

- Maternity Case Management and Babies First nurse home visiting programs will develop public health nurse practice guidelines for breastfeeding support at the population-based individual level of practice based on nursing standards.

- Continue education for health professionals in breastfeeding management across the state (3 day Breastfeeding Basics course, 5-day Advanced Breastfeeding course and sponsorship of WIC staff to take the International Board of Lactation Consultants Exam will continue).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	98.8	99.1	99.4	99.7	99.5
Annual Indicator	93.4	95.4	93.5	97.6	96.4
Numerator	43310	44594	45516	48205	46448
Denominator	46357	46763	48684	49373	48190
Data Source					Or. Ctr Health Stats and EHDI Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2008
For 2008, 93.9% of newborns in Oregon were screened for hearing before hospital discharge. This is 3.7 percentage points lower than 2007 but comparable to both 2006 (93.5%) and 2004 (94.9%).

2004: denominator = 45,660; percentage = 94.9%
2005: denominator = 45,905; percentage = 97.1%

Notes - 2007
Source: Numerator: EHDI Reporting System; Demoninator: Oregon Center for Health Statistics.

Notes - 2006
Denominator is provisional resident births for 2006, unadjusted for infant deaths.

a. Last Year's Accomplishments
Note on the data: For 2008, 93.9% of newborns in Oregon were screened for hearing before hospital discharge. This is 3.7 percentage points lower than 2007 but comparable to both 2006 (93.5%) and 2004 (94.9%).

- The Office of Family Health (OFH), Early Hearing Detection and Intervention (EHDI) Program, in collaboration with partners from the Newborn Hearing Advisory Committee and others, continued to provide technical assistance and support to hospital newborn screening programs, diagnostic centers and early intervention facilities to promote early identification and intervention for children with hearing loss.

- On-going technical assistance was provided to hospital newborn hearing screening programs, diagnostic audiology centers, and early intervention programs regarding the reporting and follow-up protocols. In addition, the EHDI Program provided reports and feedback to these facilities assisting in ensuring infants receive necessary follow-up services. Increased contact and coordination was promoted with infants' medical homes regarding their hearing status.

- The EHDI staff hired a Parent Coordinator to establish a Parent-to-Parent mentoring program for parents who have newly identified children with hearing loss. The EHDI Program created and disseminated informational brochures to parents about hearing screening and evaluation along with a "Parent Roadmap" to inform families of next steps to follow-up on their baby's hearing

health. EHDI staff made a number of presentations to health care providers, including local public health departments, and early intervention staff about the EHDI program.

- EHDI Program staff participated in a statewide work group of parents and professionals to establish improved services to families of infants with hearing loss, including improved referral processes to Early Intervention. The parents participating in this group established an Oregon Chapter of Hands & Voices.

- System enhancements are being developed to improve access to EHDI data for generating letters and to collect information from non-hospital newborn hearing screening facilities. New Screening Facility sites were trained in reporting results to EHDI. Data quality improvement activities are being conducted to ensure the accuracy of individual results.

- The EHDI Program and Oregon Dept. of Education/Early Intervention Program have worked on improving protocols so that children at risk of hearing loss because of repeated failed screenings that are near 6 months of age are reported to Early Intervention and receive follow up. This revision has improved the number of children getting enrolled in early intervention before the 6 month goal.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement legislation requiring all hospitals with 200 or more births to conduct newborn hearing tests			X	X
2. Newborn data linking project includes diagnostic and early intervention data for children				X
3. Public education materials, such as the Newborn Handbook, provide information about hearing screening				X
4. Advocacy for policies and legislation to assure screening and referral access for all newborns				X
5. Technical assistance and consultation to screening and diagnostic centers and organizations				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- EHDI is currently working on facilitating Pediatric Audiology Training for audiologists around the state to ensure children are appropriately being tested and that audiologists are knowledgeable about the evaluation procedures and new developments in hearing health.

- EHDI is currently working on providing free hearing screening clinics for the uninsured and out of hospital births. In 2009 EHDI established free clinics in the three largest out of hospital birth counties but is looking to increase the number to have clinics around the state.

- A statewide Pediatric Audiology Work group is developing best practice standards for behavioral testing of infants. The EHDI Diagnostic Audiology protocol is also being reviewed and revised, as necessary for changes in technologies.

- EHDI is currently working on improving the loaner hearing aid bank accessibility and improved

hearing aids so that they are available for uninsured children in need of hearing aids.

c. Plan for the Coming Year

- EHDI plans to partner with Oregon Health and Science University (OHSU) to provide hearing evaluations for the uninsured and in rural communities without access to the necessary testing.

- EHDI is working with the EHDI Advisory Board to plan a Statewide conference in 2010 that will focus on reducing the loss to follow-up that need further evaluation.

- EHDI will be working with the Oregon Lions Hearing Foundation to pilot a hearing screening project for infants in remote locations.

- The Office of Family Health and EHDI Program will continue to provide technical assistance and support to screening and non-screening birth facilities/providers, diagnostic centers and early intervention sites.

- Education and training is provided through presentations to groups, which include providers, local public health staff and other identified community partners regarding the EHDI program protocols and information about hearing loss issues and resources.

- EHDI follow-up staff will continue to contact families, medical home providers and local public health to assist families in navigating the system.

- Progress will continue on activities related in the CDC and HRSA early hearing detection and intervention grants, related to follow-up system development, provider and parent education and family support. The CDC-EHDI grant has been renewed until 2011 and the HRSA UNHSI Grant has been renewed until 2011.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9	9	9	12	12
Annual Indicator	12.0	12.0	12.6	12.2	12.2
Numerator	101616	101616	119376	104057	104057
Denominator	848001	848001	947427	854842	854842
Data Source					Natl. Survey Child. Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	10	10	10	10

Notes - 2008
The correct percent of children without health insurance for the years 2004-2006 is 13%.

The percent of children 0-19 without health insurance declined from 13.0% to 12.6% from 2004 to 2006. The 2007 number (12.2%) is not directly comparable to the earlier numbers for two reasons: 1) it comes from the National Survey of Children's Health (NSCH) whereas the prior numbers come from the Oregon Population Survey; 2) the NSCH only covers children 0-17. Moreover, the NSCH was conducted in 2007 and does not account for the increase in unemployment (and likely concurrent increase in uninsurance) in 2008).

Notes - 2007
Source: National Survey of Children's Health, 2007.

Notes - 2006
Population Health Survey available every other year; numerator is calculated based on population of children 0-19 as of 2005. The question on health insurance coverage was dropped after 2006 due to data inconsistencies.
The correct percentages for both 2004 and 2005 is 13%

a. Last Year's Accomplishments
Note on the data: The percent of children 0-19 without health insurance declined from 13.0% to 12.6% from 2004 to 2006. The 2007 number (12.2%) is not directly comparable to the earlier numbers for two reasons: 1) it comes from the National Survey of Children's Health (NSCH) whereas the prior numbers come from the Oregon Population Survey; 2) the NSCH only covers children 0-17. Moreover, the NSCH was conducted in 2007 and does not account for the increase in unemployment (and likely concurrent increase in uninsurance) in 2008).

- The Governor's Healthy Kids Plan, to provide health coverage for every Oregonian child using an 84.5 cent increase in Oregon's tobacco tax, was introduced to the 2007 Legislature. While the insurance coverage received bi-partisan support, the increased taxes did not. Therefore, the Plan and tobacco tax increase was referred to the voters for a constitutional amendment, which failed to pass.

- Title V Programs in OFH and OCCYSHN continued to work with partners to strengthen benefits counseling for improved utilization of existing coverage and services for children with special healthcare needs, and enhanced outreach efforts to increase enrollment in public and private health insurance programs.

- The Universal Application System called "Oregon Clicks" did not find stable funding during Oregon's biennial legislative session, nor was the pilot deemed successful in achieving its goals. Therefore, the "Oregon Clicks" was not renewed.

- DHS Office of Family Health staff continued to work with the Oregon Health Plan and Office of Medical Assistance Programs to enhance outreach efforts, coordination, and simplification of the Medicaid application process, including simplifying initial and re-application materials, simplifying the procedures for obtaining application forms, and simplifying application completion by identifying nontraditional community-based application sites throughout the state.

- Oregon School-Based Health Centers offered a variety of OHP enrollment programs based on

the local resources, including school-based outreach workers and health department employees that facilitate bilingual and expedient enrollment

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and application assistance through local health department programs and home visiting programs		X	X	
2. Information and referral through toll-free number, SafeNet.		X	X	
3. Coordination and collaboration in MCH programs to simplify application.				X
4. Policy advocacy to sustain eligibility levels for Oregon Health Plan for children 0-18.				X
5. Collaboration to strengthen early childhood linkages with healthcare coverage initiatives.				X
6. Policy advocacy to maximize third party reimbursement for developmental screening, assessment, promotion and prevention services, and care coordination.				
7. Oregon Title V MCH programs promote universal comprehensive insurance and healthcare for expectant parents, children, adolescents, children and youth with special health needs, and their families				X
8.				
9.				
10.				

b. Current Activities

- Title V Child Health programs continue to find opportunities to promote universal comprehensive insurance and healthcare for MCH populations through programs, policy development, collaborative leadership, and other activities across state and local programs.

- The Title V Director and the Adolescent Health Section Manager are participating in the executive steering committee that is overseeing the implementation of the Governor's Healthy Kids Plan legislation that expands insurance availability to children 0-18.

- Public health nurses in all MCH programs (Maternity Case Management, Babies First, CaCoon) assess their clients for insurance coverage and refer to Medicaid if appropriate) and provide families with children birth to age five with case management services that include assistance in accessing and utilizing Medicaid services. The CaCoon promatoras assist Spanish-speaking families to complete Medicaid applications.

c. Plan for the Coming Year

- 2009-2010 will mark a year of change for increasing access to insurance for Oregon's children and youth. The Governor's Healthy Kids Plan 2009 creates hospital and insurer taxes that will fully fund the Healthy Kids Plan, providing health insurance to all Oregon children 18 and under and funds rebuilding the Oregon Health Plan Standard program, adding about 80,000 uninsured children and at least 25,000 more adults. This legislation is approved and due to be signed by the Governor in early July.

- The Healthy Kids Plan (HKP) legislation provides coverage for children will be continuous for 12 months and applications are more simple. Children in families with incomes 200% or less of

Federal Poverty Level will pay not premium or co payment for Oregon Health Plan coverage, or, if they have employer-sponsored insurance, will receive full premium assistance and will pay a co-payment for services. For children of families with incomes between 200% and 300% of Federal Poverty Level, state will assist with premium payment for both employer-assisted insurance and for the Oregon Health Plan, and they will pay a co-payment for services. Children in families with incomes over 300% FPL and no employer assisted insurance, may purchase enrollment in the Oregon Health Plan by paying the full premium amount and the copyment for services.

- The Division of Medical Assistance Programs (DMAP) is developing strategies for marketing, outreach, and enrollment. Funding will be available to fund community organizations to conduct outreach and enrollment assistance for those families with children most difficult to enroll.

- Title V programs will be working with community partners and stakeholders to assure awareness of the HKP and support education and training, assuring partnership with HKP outreach workers.

- Over the next year, the Adolescent Health program will be convening a policy effort aimed at exploring options to expanding health coverage for older adolescents and young adults (ages 18-25). This will include having a dedicated graduate intern and bringing together representatives from private health insurance, Medicaid, youth and other stakeholders to discuss options, barriers, and come up with a proposal for moving forward.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			31	33	33
Annual Indicator		31.2	31.8	32.1	32.1
Numerator		33437	14255	14613	14613
Denominator		107169	44826	45525	45525
Data Source					Pediatric Nutrition Surveillance Survey, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32	32	31	30	30

Notes - 2008
Data carried over from the most recent Pediatric Nutrition Surveillance Survey, 2007. Both 2006 and 2007 data show that approximately 32% of Oregon WIC clients between the ages of 2-5 years have a BMI above the 85th percentile.

Notes - 2007

Source: Pediatric Nutrition Surveillance Survey.

Notes - 2006
The data entered here is cumulative data for 2003-05 from the Pediatric Nutrition Surveillance Survey.

a. Last Year's Accomplishments
Note on the data: Both 2006 and 2007 data show little change that approximately 32% of Oregon WIC clients between the ages of 2-5 years have a BMI above the 85th percentile.

- All local agencies received tool kits for promoting physical activity with WIC participants, including lesson plans and activity cards parents can use with their preschool children.

- One goal of the FFY 2007-2008 WIC Nutrition Education Plan was to improve the health outcomes of clients and staff in the local agency service delivery area. As part of that NE Plan, local agencies used data on prevalence of nutrition risk factors to assess their nutrition education activities and target them to the most prevalent risks.

- Local agency WIC staff were trained in the new Nutrition Risk Module which focuses on appropriate risk assessment and critical thinking, including assessing for overweight and risk of overweight.

- WIC staff, in collaboration with the Nutrition Council of Oregon, developed and extensively field tested nutrition education materials aimed at increasing parental awareness of marketing unhealthy foods to young children. The resulting poster has been was distributed in both English and Spanish to all WIC agencies, Head Start programs, dental offices and other interested community partners.

- WIC staff began work towards the implementation of the new WIC food package, which must be fully implemented by October 2009. Changes to the food package support the Dietary Guidelines for Americans and may impact the weight in children and adults by only providing lower fat milk, less cheese, more whole grain options and a cash benefit to purchase fresh and frozen fruits and vegetables.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and monitor weight status for all WIC clients between 2-5 years of age; provide counseling to all parents on ways to promote healthy weight; clients at highest risk are referred to RDs, their medical provider and/or other resources in the comm	X	X		
2. Participate in and promote the following nationwide public health campaigns: National Breastfeeding Week, TV Turn-off, Fruits and Veggies More Matters promotion			X	X
3. Improve the health outcomes of clients in the local agency service delivery areas through technical assistance and training for implementation of local Nutrition Education Plans			X	X
4. Continue implementation with a participant-centered approach to working with WIC families to identify their concerns and priorities around addressing and preventing overweight in children.	X	X		
5. Collaborate with state nutrition programs and groups in identifying best practices for promoting healthy weight in families across Oregon.			X	X

6.				
7.				
8.				
9.				
10.				

b. Current Activities

- As part of the FFY 2008-2009 NE Plan, local agencies selected appropriate strategies and objectives from the Statewide Physical Activity and Nutrition Plan for their population and setting.

- WIC continues to work towards the implementation of the new food package changes which will occur August 1, 2009. Changes to the food package support the Dietary Guidelines for Americans and may impact the weight in children and adults by only providing lower fat milk, less cheese, more whole grain options and a cash benefit to purchase fresh and frozen fruits and vegetables.

- Local agencies began distribution of the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon. This kit includes resources to promote healthy eating and physical activity targeting children ages 2-5.

- Local WIC staff were trained in participant-centered skills to use with WIC families. These skills help WIC families to identify their concerns and priorities around addressing and preventing overweight in children.

- Staff have begun modifying the curriculum for "Breastfeeding Basics" and for the Breastfeeding Training Module to incorporate participant centered counseling skills and information from a California research project on Infant Cues to better support breastfeeding exclusivity and duration.

c. Plan for the Coming Year

- The FFY 2009-2010 Oregon WIC Program Nutrition Education Plan is designed to support and promote a comprehensive approach in the delivery of WIC services. This structure involves a three-year strategy focusing on providing quality nutrition services, including nutrition assessment and education in preparation for the federally mandated implementation of the Value Enhanced Nutrition Assessment (VENA) project. The multi-year plan will continue to support the Oregon Statewide Nutrition and Physical Activity Plan, Breastfeeding Promotion, and MCH Title V National Performance Measures.
- As part of the FFY 2009-2010 NE Plan, local agencies will develop a plan to consistently promote the Oregon WIC Key Nutrition Messages related to the food package changes thereby supporting the foundation for health and nutrition of all WIC families.
- Local agencies may continue to distribute the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon.
- For the first time, WIC will be issuing vouchers to women and children for the purchase of fresh and frozen fruits and vegetables.
- WIC will continue to work as a partner with other USDA FSN programs through the Supplemental Nutritional Assistance Program (SNAP) collaboration to plan and implement a variety of physical activity and fruit and vegetable promotion.
- WIC will continue to play an active role in the Breastfeeding Coalition of Oregon, in the other areas related to breastfeeding promotion and support.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			11.6	12	10
Annual Indicator		12.1	10.7	10.3	10.3
Numerator		201	4939	4883	4883
Denominator		1661	46146	47614	47614
Data Source					PRAMS 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	9.5	9.5	9	9

Notes - 2008
From weighted PRAMS data, this measure is showing a decline in the percentage over the past 3 years from 12.1% (2005) to 10.7% (2006) to 10.4% (2007). PRAMS 2008 data is not yet available, so 2007 data is carried over.

Note: the PRAMS data for 2003-2005 in the 2006 Note for NPM #15 is no longer valid.

Notes - 2007
Source: PRAMS, 2006; weighted data.

Notes - 2006
Source: PRAMS, 2006; weighted data.

The data for 2005 should be corrected; PRAMS 2005 data is the most recent available and the follwoing shows trends over last few years. This is unweighted data:

2003: 12.1% (N=201. D= 1661 PRAMS respondents who reported they smoked during pregnancy.)

2004: 13.7% (N=235, D=1909 PRAMS respondents who reported they smoked during pregnancy)

2005: 13.7% (N=249; D=1866 PRAMS respondents who reported they smoked during pregnancy)

a. Last Year's Accomplishments
Note on the data: From weighted PRAMS data, this measure is showing a decline in the percentage over the past 3 years from 12.1% (2005) to 10.7% (2006) to 10.4% (2007). State Performance Measure 2 complements National Performance Measure 15, although the state measure is focused on surveillance of continued cessation beyond pregnancy.

- Partnerships with the Division of Medical Assistance Programs (DMAP), local providers and

agencies, and the Center for Health Training (Seattle) continued to result in provision of training, information, and education on the 5 A's protocol, motivational interviewing, and the DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

- The Maternal and Child Health Program continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.

- State Public Health Division continues to implement an Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures during Pregnancy." As a collaborative effort between the Office of Family Health (Title V) and the Environmental Health Section within the Public Health Division, the pilot project has been implemented in two county health departments. The project provides environmental assessment and interventions to address issues of the pregnant woman who smokes and her and her infant's exposure to second hand smoke. The revised environmental assessment tool and resource guide are both currently being piloted.

- Action plans were prepared for Preconception Health and for Maternal Depression, based on priority setting process with local public health nurses. Smoking prevention and cessation and relationship to healthy births and depression, is included in both these action plans.

- The Office of Family Health was awarded a HRSA grant to fund a social marketing pilot project, "Passing on Strengths" to first generation Hispanic women in Southern Oregon counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance to local Maternity Case Management (MCM) providers on the Five A's Intervention and motivational interviewing for pregnant women.		X		X
2. Implement Demonstration Project in two counties to build capacity to address environmental exposures during pregnancy including second hand smoke.		X		X
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family Planning client services		X		
6. PRAMS-2 (2-year old PRAMS follow up) data surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
7. ORCHIDS (Oregon Child Health Information Data System) state and local level data reports on reported tobacco exposure during pregnancy and home visitor interventions to evaluate trends and level of intervention provided in MCH programs.				X
8.				
9.				
10.				

b. Current Activities

- Partnerships between DMAP, local providers and agencies will continue in order to provide training, information, and education on the 5 A's protocol and the use of the revised 2008 DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

- Continued cessation screening and counseling for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.

- PRAMS-2 (PRAMS 2 year old follow up survey) from 2007, second year of data collection, is being finalized and will begin analysis during 2009.

- The Oregon Child Health Information Data System (ORCHIDS) Maternal Child Health Data Entry (MDE) system for local service providers and agencies is collecting statewide data on pregnant women who smoke including attempted smoking cessation in last 12 months, smoking frequency, other household smokers, household smoking rules, movement on the change spectrum regarding numbers of cigarettes per day and provider use of 5A's brief interventions for smoking cessation. Systematized Continuous Quality Improvement is being implemented to improve reporting and validity of reports for program evaluation and population surveillance.

- The Preconception Action Plan will address prevention of smoking in younger girls by looking towards future pregnancies.

c. Plan for the Coming Year

- Partnerships will continue with DMAP, local providers and agencies in training, information, and education on the 5 A's protocol and the 2008 revised DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

- Cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC will continue during 2010.

- Evaluation of county client data reports from ORCHIDS will improve surveillance and monitoring on tobacco exposure during pregnancy and provider interventions. The information will be used by the Perinatal Title V Program to plan for strategies in program services delivered by county health department partners.

- The Preconception Health Action Plan will continue planning and implementation of public health programs that address smoking prevention and cessation as it relates to future pregnancies of clients of health department partners.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8	6	6	7	7.5
Annual Indicator	6.2	7.4	8.1	8.4	10.1
Numerator	16	18	20	21	26
Denominator	256544	244360	246476	248780	256673
Data Source					Oregon Center for Health

					Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.5	9	8	7	6.5

Notes - 2008
The rate of suicide deaths among teenagers has increased steadily over the years from 6.2 per 100,000 in 2004 to 10.1 in 2008. However, given the infrequent nature of these events, this trend should be interpreted cautiously.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments
Note on the data: The rate of suicide deaths among teenagers has increased steadily over the years from 6.2 per 100,000 in 2004 to 10.1 in 2008. However, given the infrequent nature of these events, this trend should be interpreted cautiously.

- The Youth Suicide Prevention (YSP) program was in its second year of grant funding from the Garrett Lee Smith Memorial Act (GLSMA). In 2008, The three site prevention coordinators worked with 7 local steering committees, became trainers, held trainings, increased local awareness of the problems, worked to implement RESPONSE programs in local high schools, and implemented 2 new bereavement support groups. In addition, Warm Springs held a regional youth conference for over 300 youth, a family retreat, and a conference with elders in suicide prevention.

- Increasing capacity in suicide intervention skills continued to be a priority. The YSP program helped sponsor an Applied Suicide Intervention and Skills Training (ASIST) Training for Trainers in January and 9 Oregonians became ASIST trainers, including the 3 regional site prevention coordinators for the GLSMA grant, two members of a county coalition in Central Oregon, and two Oregon National Guard staff. They held eight evidence-based, 2-day ASIST trainings in Oregon in 2008. There were over 26 trainings held throughout Oregon.

- Thirty-three people became QPR (Question, Persuade, Refer) trainers in Oregon including 3 who are bilingual in Spanish. The trainers affiliated with the YSP program held 31 QPR trainings, training 1,226 people.

- The 3 regional GLSMA sites met with school districts in their 7 counties to introduce RESPONSE, a comprehensive, high school-based program named a Best Practice by SPRC and AFSP. Where RESPONSE was implemented, pre-post- tests showed an increase in knowledge, attitudes, and behaviors among participants.

- Union County, in collaboration with Blue Mt. Community College (BMCC), held a 2-day evidence-based training, Recognizing and Responding to Suicide Risk, for mental health and law enforcement professionals and a QPR Training for Trainers.

- The YSP program worked with Portland State University (PSU) and Macro (national evaluators for GLSMA) to provide cross-site evaluation data on program activities and to obtain evaluation results from trainings in QPR, ASIST, and RESPONSE. PSU also administered follow-up surveys with participants six-months after the trainings.

- The GLSMA regional sites worked with local groups to increase participation in bereavement support groups for families and individuals affected by suicide and established 2 new bereavement groups in 2 regions.

- The YSP program contracted with Oregon NAMI (National Alliance on Mental Illness) to start a statewide suicide prevention coalition.

- The YSP program collaborated with the Oregon University Consortium and BMCC on their GLSMA grant projects, serving on BMCC's Advisory Board until their grant funding ended September 30.

- The YSP Coordinator participated as an advisory board member to the mental health component of Healthy Kids Learn Better, Oregon's Coordinated School Health Program.

- Twice a year the state and local Child Fatality Review teams review all youth suicides that occur in Oregon. The YSP program reviews 3 suicide deaths at each state review team meeting. In the fall of 2008, the meeting included a presentation on school-based prevention following four suicide deaths in one Jackson County school district. County law enforcement, a county YSP coordinator, and the county child fatality review coordinator attended the meeting to brainstorm collaborative prevention measures with the state team. The YSP Coordinator represents the Youth Suicide Prevention Program on the State Child Fatality Review Team.

- The Adolescent Suicide Data System (ASADS) reporting form was revised to improve surveillance data by requesting named reporting and intent and providing definitions for suicidal behavior. The system moved from the Center for Health Statistics to the Injury Prevention Epidemiology section in the Health Division. The revised ASADS reporting form was implemented into hospital emergency departments on January 1, 2008.

- The Yamhill County Suicide Prevention Coalition developed a community video and discussion guide on suicide prevention called "Breaking the Silence."

- The YSP Coordinator presented QPR trainings to NARA, the Coquille, and Burns-Paiute Indian tribes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Focus state and local efforts on best practice and evidence-based practices described in the State Suicide Prevention Plan.				X
2. Provide and facilitate training for providers, counselors, educators, and others on youth suicide prevention strategies.		X		X
3. Assess and monitor trends in youth suicides and suicide attempts through surveillance and participation on the State Child Fatality Review Team.				X
4. Train school teams to implement RESPONSE in high schools as part of the Garrett Lee Smith Memorial Act (GLSMA) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).		X		X

5. Increase capacity in suicide intervention skills training throughout Oregon to crisis responders, clinicians, school staff, parents, and lay people as part of the GLSMA grant.		X		X
6. Encourage and support Bereavement Support activities.				X
7. Provide a medium for exchange of research findings, trainings, collaboration, news, and local events through a statewide listserv.			X	X
8. Educate the media on prevention and provide nationally-developed guidelines to increase safe reporting of high-profile suicides.			X	X
9.				
10.				

b. Current Activities

- The YSP program and GLSMA grant sites:
• Evaluate ASIST, QPR, and RESPONSE programs
• Provide evaluation findings on GLSMA-funded projects
• Started 2 more suicide bereavement groups
• Conducted a statewide suicide prevention conference
• Held an "Assessing and Managing Suicide Risk" training for mental health professionals

- The YSP Coordinator collaborates with NARA and Oregon tribes on youth suicide prevention activities.

- The YSP program applied for a new, competitive GLSMA grant through SAMHSA for 3 years of funding beginning in fall 2009. The program received approval for a 12-month no-cost extension on the current grant

- The YSP program distributes Yamhill County's video and discussion guide, "Breaking the Silence" to build community awareness and participation in prevention.

- The YSP program works with the National Guard to increase intervention skills training and to prevent suicides through the Guard, their reintegration teams, and their family support services networks.

- The state Injury Prevention epidemiologist will analyze data from the 2008 revised ASADS reporting system forms to help inform further actions with hospital emergency departments and prevention efforts.

- The YSP program works closely with epidemiologists in Injury Prevention and the Oregon Violent Death Reporting System to discover trends and use data to inform planning and activities.

c. Plan for the Coming Year

- The YSP program will continue activities:
• Implement the GLSMA grant and provide oversight and technical assistance to the local GLSMA sites.
• Support regional sites in implementing RESPONSE.
• Support broader efforts in Oregon to implement RESPONSE.
• Facilitate increasing the number of QPR trainers and trainings available throughout Oregon, including trainings in Spanish to Hispanic communities and groups.
• Facilitate increasing the number ASIST trainers and trainings available throughout Oregon.
• Support and provide technical assistance to local coalitions and youth suicide prevention efforts throughout Oregon.
• Work with Regional Research Institute, Macro, and GLSMA sites to evaluate youth suicide

prevention programs, including enhanced follow-up evaluation of selected trainings and a qualitative study.

• Provide staff support for statewide coalition on suicide prevention.

• Provide technical assistance and program support to the Healthy Kids Learn Better Program including being part of the advisory board for the mental health grant sites.

• Collaborate with NARA, another Oregon GLSMA grantee.

• Deliver presentations and provide data about youth suicide including veterans and suicide; make powerpoint presentation available to others.

• Administer the regional Youth Suicide Prevention Network (YSPNetwork) listserv.

• Keep updated statistics and data and make them available through fact sheets, the YSP website, the YSPNetwork listserv and powerpoint presentations.

- Work with ASADS and hospital emergency room staff to improve reporting; follow-up on youth who have been seen for attempting suicide.

- Work with the Injury Prevention Epidemiologist and the Oregon Violent Death Reporting System Epidemiologist to report their findings and use findings to inform prevention goals and activities.

- Disseminate suicide prevention materials and information widely through the YSPNetwork listserv; keep members informed, up-to-date, and involved.

- Increase education and training on suicide prevention for lesbian, gay, bisexual, transgender, and questioning youth.

- Work to increase responsible reporting of suicide deaths in news media throughout the state.

- Work with faith-based organizations to provide education about appropriate memorial services.

- Provide materials to help funeral directors support families and survivors of suicide loss.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85	85	85	81	99
Annual Indicator	81.9	79.1	75.7	99.2	99.4
Numerator	397	375	368	475	484
Denominator	485	474	486	479	487
Data Source					Or. Ctr Health Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2008

Oregon does not have designated high risk facilities, Data from 2007 forward is based on very low birthweight infants born in hospitals. Previous years based on very low birth weight infants born at the 6 Oregon hospitals with NICUs.

Notes - 2007
Source: Hospital Discharge Data, 2007.

Previous year reported from 6 hospitals with NICUs. 2007 data is reporting from all hospitals and birthing centers.

Oregon does not have designated high risk delivery facilitiies, so numerator is based on very low birthweight infants born in hospitals.

Notes - 2006
Oregon does not have designated high risk delivery facilitiies, so numerator is based on very low birthweight infants born in hospitals.

a. Last Year's Accomplishments
Note on the data: Previous year, 2004-2006, reported from 6 hospitals with NICUs. 2007 data is reporting from all hospitals and birthing centers. Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

- There are 56 hospitals in the state that provide obstetric care. Seven have NICUs. In Oregon, there is no regulated designation for an NICU. The NICUs are staffed with Neonatologists and are Level III by the AAP Perinatal Levels of Care. The Oregon NICUs are: Providence St. Vincent's, Legacy Emanuel Hospital , Doernbecher Hospital NICU (OHSU) all in the Portland Metro area;, Salem Hospital in Salem, Sacred Heart Medical Center in Eugene, Rogue Valley Medical Center in Medford, and St. Charles Medical Center in Bend.

- OHSU provided consultation to providers caring for high risk deliveries & neonates, funded in part by OFH.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocacy for assuring systems in place to appropriately care for VLBW infants				X
2. Assessment and surveillance of status of VLBW infants among all population groups			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
- Oregon, a primarily rural state, believes women in pre-term labor should be transported to the nearest facility, not to a facility that is experienced in the care of very low birth-weight neonates that often requires long distance travel to the urban center (Portland or Eugene).

- OHSU provides consultation to providers caring for high risk deliveries & neonates, funded in part by OFH.

- The OCCYSHN CaCoon Nurse Consultant attends weekly rounds in the NICU at OHSU and communicates updates on resources to discharge coordinators in the other NICUS around Oregon

- OCCYSHN is developing a public health nursing webpage that will replace the web portal that was formerly used to inform providers about resources.

c. Plan for the Coming Year

- OFH will initiate collaborations to evaluate the feasibility of implementing statewide local Fetal Infant Mortality Review (FIMR). FIMR can be used to assess plan, improve and monitor service systems as well as broad community resources that support and promote the health and well-being of women, infants, and families. Information from FIMR will inform this performance measure as well as other positive system improvements to assure healthy Oregon Families.

- OCCYSHN will continue working on the development of a public health nursing webpage which will include information on the care of premature and high risk infants in the community

- OCCYSHN will offer several webinars on the care of children with special health care needs.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85	85	85	82	82
Annual Indicator	81.5	81.0	79.2	78.4	78.4
Numerator	38532	36610	38475	38484	38484
Denominator	47290	45195	48559	49078	49078
Data Source					Oregon Center for Heatlh Statistics 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	81	81	82

Notes - 2008

Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation and therefore, 2008 data is not yet available.

In recent years, there has been a small decrease in the percentage of women who have received prenatal care beginning in the first trimester, from a high of 81.0% in 2004 to a low of 78.4% in 2007.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments
Note on data: In recent years, there has been a small decrease in the percentage of women who have received prenatal care beginning in the first trimester, from a high of 81.0% in 2004 to a low of 78.4% in 2007. Beginning with 2008 births, Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth. Several variables will be used to determine whether a pregnant woman had first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation.

In 2007, Oregon ranked 33rd in the nation for adequacy of prenatal care (United Health Foundation America's Health Rankings, 2008). However, the OHSU Women's Health Report Card ranks Oregon 37th in the country for first trimester care (based on 2003 data). Presumptive eligibility facilitates early entry into prenatal care by guaranteeing that care delivered before OHP eligibility is formally established will be reimbursed. Women in Oregon often cannot see a prenatal care provider until the source of payment for care is determined because providers are reluctant to initiate care without having OHP or other coverage confirmed. Presumptive eligibility is the current Medicaid practice in 31 states (National Women's Law Center, 2006).

- Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, provides services at 29 sites in an effort to link women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds.

- The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include a toll-free hotline (SafeNet), a referral and support system, to assist women in finding and using prenatal services, including dental services, in their community, and an ongoing public awareness, outreach, and education campaign. During 2008, the program assisted 5,111 women in gaining access to prenatal services.

- The Office of Family Health (Title V Program) continued to provide funding and technical assistance to local health departments to support Maternity Case Management (MCM) and home visiting services in an effort to increase access and effective utilization of prenatal care and other services. All county health departments had the option of allocating Title V and state funding to a local Oregon MothersCare (OMC) site; a first trimester pregnancy access program. In addition, a dedicated portion of Title V funds was distributed to existing OMC sites.

- OFH provided funding and technical support to local health departments to provide maternity case management to women without public or private insurance.

Current Activities 2009
HB2729 in the 2009 Oregon Legislature would have provided presumptive eligibility for pregnant

women enrolled in the Oregon Health Plan, but was not passed this year. The Healthy Kids Plan and other reforms were a priority in this year's session.

- Oregon Health Plan eligibility for pregnant women remains at 185% of Federal Poverty Level.

- As part of the "Preconception Health" Initiative, the Office of Family Health (Title V MCH Program) was awarded the Health Resources and Services Administration (HRSA) grant, "First Time Motherhood/New Parents Initiative" to fund a preconception social marketing project in Oregon titled "Passing on Strengths." This campaign addresses issues prior to the first pregnancy and continuing through subsequent pregnancies in Oregon's second generation population of Latina immigrants. The project is in the final stages of soliciting a contractor to develop the "Passing on Strengths" campaign.

- As part of the "Perinatal Depression" initiative distribution is currently underway of a toolkit to local communities for needs assessment activities. Perinatal depression impacts the adequacy and timeliness of prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach and link women to early and adequate prenatal care		X	X	
2. Maternity case management and home visiting services for high risk pregnant women		X	X	
3. Reproductive health and family planning services provide education about optimal prenatal care		X	X	
4. ORCHIDS client data system provides data to assess status of client risk factors and needs				X
5. PRAMS surveillance provides information about utilization, access, and quality of prenatal care				X
6. Advocacy for early prenatal care system and quality improvements				X
7. WIC and Family Planning programs refers women screening positive for pregnancy		X	X	
8.				
9.				
10.				

b. Current Activities

- Oregon Health Plan eligibility for pregnant women remains at 185% of Federal Poverty Level.

- As part of the "Preconception Health" Initiative, the Office of Family Health (Title V MCH Program) was awarded the Health Resources and Services Administration (HRSA) grant, "First Time Motherhood/New Parents Initiative" to fund a preconception social marketing project in Oregon titled "Passing on Strengths." This campaign addresses issues prior to the first pregnancy and continuing through subsequent pregnancies in Oregon's second generation population of Latina immigrants. The project is in the final stages of soliciting a contractor to develop the "Passing on Strengths" campaign.

- As part of the "Perinatal Depression" initiative distribution is currently underway of a toolkit to local communities for needs assessment activities. Perinatal depression impacts the adequacy and timeliness of prenatal care.

c. Plan for the Coming Year

- Continue to update and re-vitalize Oregon MothersCare (OMC), a program to improve access to early prenatal care, including dental care, assist local health departments and other OMC access sites to: formalize partnerships with prenatal care providers and other providers offering pregnancy related services, promote SafeNet, the toll-free hotline for referrals to local prenatal services; streamline systems for accessing care; and assist women to obtain a pregnancy test, OHP, a prenatal care provider, and WIC, maternity case management or other pregnancy services. OMC also supports the "First Time Motherhood".

- In an effort to serve a larger population, all county health departments have the option of applying Title V and state funding to assist in the development and operations of a local Oregon MothersCare (OMC) site. Title V funds are being allocated specifically to support Oregon MothersCare through a funding formula.

- Collaboration and support will continue with community-based efforts to increase access to prenatal care and improve birth outcomes.

- Early access to prenatal care will be included as critical element of the Action Plans for the Preconception Health and Maternal Depression Initiatives.

- Implement the "Passing on Strengths" campaign for second generation Latina immigrants.

D. State Performance Measures

State Performance Measure 1: *Percent of births where mothers report that the pregnancy was intended*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			62.7	63	63.4
Annual Indicator	62.9	62.0	62.1	60.6	60.6
Numerator	28720	28456	30025	28571	28571
Denominator	45660	45905	48336	47183	47183
Data Source					PRAMS 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63.8	63.8	63.8	64.5	64.5

Notes - 2008

Most recent data is weighted PRAMS data, 2007, carried over for 2008. Data indicate a small decline in pregnancy intendedness, from a high of 62.9% in 2004 to a low of 60.6% in 2007. All numbers are below the Healthy People 2010 objective of 70%.

Notes - 2007

Source: Weighted 2007 PRAMS data

Notes - 2006

Source: PRAMS, 2005. Weighted numerator and denominator

a. Last Year's Accomplishments
Note on the data: PRAMS weighted data in 2007 indicate a small decline in pregnancy intendedness, from a high of 62.9% in 2004 to a low of 60.6% in 2007. All numbers are below the Healthy People 2010 objective of 70%.

- The Oregon Family Planning Program served 62,838 clients in clinics supported by Title X and Title V funds preventing an estimated 11,300 unintended pregnancies. An additional 50,734 Oregonians received family planning services through clinics participating in the Medicaid waiver Family Planning Expansion Project (FPEP).

- A total of 110,064 female clients were served, representing approximately 45% of the estimated Women in Need (WIN) supplying publicly-funded contraceptive services and supplies in Oregon.

- In addition to contraceptive services provided and pregnancies averted, these clinical programs provided basic preventive health care services and exams for 113,572 women and men. Over 38,000 Pap smears and 45,000 clinical breast exams were done in family planning clinics.

- Family planning clinics continued to face financial challenges caused, in part, by static Title X funding. Further, the FPEP eligibility changes (particularly around citizenship documentation) have been a particular hardship for clinics supported by Title X funds. As a condition of their federal funding, these clinics must provide services to anyone seeking care, regardless of that person's ability to pay. Clients who no longer qualify for FPEP must still be seen and their income levels generally qualify them for free or substantially discounted services. The result is that these clinics must somehow meet the same level of client need while operating with significantly less revenue.

- Research on the impact of the FPEP eligibility changes has demonstrated a 33% decline in client numbers between 2005 and 2008. Further analyses of family planning visits by time period and payor has demonstrated that teenage and African American clients have been particularly affected by the eligibility changes, with a 47% decline in visits among teenage clients and a 49% decline in visits among African American clients.

- Continued ongoing quality assurance activities, including on-site evaluations of local family planning clinics, reviews of grant program annual plans, and FPEP chart audits to determine appropriateness of services billed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family planning and reproductive health programs provide preventive clinical services for all women		X		
2. Training and education for clinic staff to ensure that providers are up-to-date on clinical information and techniques, best practices in client counseling and education, and program requirements				X
3. Outreach and referral in communities to increase access and utilization of family planning services			X	
4. Technical assistance and consultation for Comprehensive Clinic Program Efficiency (COPE) quality improvement				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

- It is estimated that nearly 12,000 unintended pregnancies were averted in 2008 because of services provided in Title X and Title V MCH-supported clinics. Our goal is to maintain current resource levels so as to continue providing family planning services to low-income Oregonians.

- In order to increase client volume at family planning clinics a statewide FPEP transit ad campaign was implemented in early 2009. This outreach campaign will be followed in the fall of 2009 by a social marketing campaign utilizing web 2.0 technology to reach 19-29 year olds in need of family planning services.

- Priority requirements continue to be implemented by the Title X program, including increasing involvement of male partners in family planning services, encouraging family participation in the decisions of minors seeking family planning services, promoting highly effective birth control methods, and providing counseling to minors on how to resist coercion into sexual activities.

c. Plan for the Coming Year

- Continue to work with agencies to support clinics despite lack of revenue. Many agencies have had to limit clinic hours, close clinic sites, lay off staff and eliminate walk-in appointments.

- Dependent upon FPEP waiver renewal application approval, remove the most prohibitive FPEP eligibility requirements and expand the menu of services covered. These changes, by increasing the number of clients and services covered by FPEP, can be expected to relieve clinics of much of the financial burden placed on limited Title X funds.

- Focus on FPEP outreach efforts to increase the number of clients utilizing family planning services.

- Continue to offer trainings and resources on clinic efficiencies to family planning clinics.

- Continue to promote, through training, technical assistance, and material development, the Culturally and Linguistically Appropriate Services (CLAS) standards to all family planning clinics.

State Performance Measure 2: *Percent of smoking women who quit smoking during their pregnancy and did not begin smoking postpartum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			57.9	64	64.5
Annual Indicator	60.8	63.6	52.0	64.6	64.6
Numerator	2633	2232	2501	3265	3265
Denominator	4328	3508	4807	5054	5054
Data Source					PRAMS 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	64.5	65	65	65	65

Notes - 2008
From weighted 2007 PRAMS data. PRAMS 2008 data is not yet available, so 2007 data is carried over.

The percent of women who quit smoking postpartum and did not begin smoking postpartum has had large swings in recent years, from a high of 64.6% in 2007 to a low of 52.0% in 2006. However, given the small sample sizes and large confidence intervals associated with this measure, these percents are not statistically different from one another. The 52.0% in 2006 has a 95% confidence interval that ranges from 39.8%-64.2% and the 64.6% in 2007 has a 95% confidence interval that ranges from 52.4% and 76.7%.

Notes - 2007
Source: Weighted PRAMS data, 2007.

Notes - 2006
Source: Oregon PRAMS

a. Last Year's Accomplishments
Note on the data: The percent of women who quit smoking postpartum and did not begin smoking postpartum has had large swings in recent years, from a high of 64.6% in 2007 to a low of 52.0% in 2006. However, given the small sample sizes and large confidence intervals associated with this measure, these percents are not statistically different from one another. The 52.0% in 2006 has a 95% confidence interval that ranges from 39.8%-64.2% and the 64.6% in 2007 has a 95% confidence interval that ranges from 52.4% and 76.7%.

- Partnerships with the Division of Medical Assistance Programs (DMAP), local providers and agencies continued to result in provision of training, information, and education on the 5 A's protocol, motivational interviewing, and the DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

- Perinatal Health Program continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.

- State Public Health Division received an Environmental Protection Agency (EPA) grant award for "Building Capacity to Address Environmental Exposures During Pregnancy." As a collaborative effort between the Office of Family Health (Title V) and the Environmental Health Section within the Public Health Division, the pilot project has been implemented in two county health departments. The project provides environmental assessment and interventions to address issues of the pregnant woman who smokes and her and her infant's exposure to second hand smoke.

- The publication of the "CD Summary: Maternal Smoking In Oregon: Helping Moms Quit" (http://www.oregon.gov/DHS/ph/cdsummary/2008/ohd5702.pdf) with distribution to licensed health care providers in Oregon and public health agencies as a collaborative effort between the Office of Family Health (Title V) and the Oregon Tobacco Prevention and Education Program.

- Action plans based on priority issues defined by a shared process with local public health nurses were prepared for Preconception Health and for Maternal Depression. Smoking prevention and cessation and relationship to healthy births and depression, is included in both these action plans.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training and technical assistance to local MCM providers on the Five A's Intervention and motivational interviewing for pregnant women		X		X
2. PRAMS-2 (2-year old PRAMS follow up) data surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family Planning client services		X		
6. ORCHIDS (Oregon Child Health Information Data System) state and local level data reports on reported tobacco exposure during pregnancy and home visitor interventions to evaluate trends and level of intervention provided in MCH programs				X
7. Pilot Project in two Oregon local health departments addressing environmental exposures during pregnancy including cigarettes and second hand smoke.				X
8.				
9.				
10.				

b. Current Activities

- Activities begun in 2008 will continue to assure women in preconception and pregnancy do not smoke before, during, or after giving birth. Activities include: cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC; Partnerships between DMAP, local providers and agencies will continue in order to provide training, information, and education 2008 DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services; and continuous quality improvement to improve ORCHIDS/MDE reporting and ensure validity of reports for program evaluation and population surveillance.

- Second year data, 2007, (both weighted and unweighted) from the PRAMS-2 (a longitudinal survey of PRAMS participants, addressing the health of mothers and their two year old which includes questions about tobacco use by the mother and in the household) is ready to be analyzed.

- The Preconception Action Plan will address prevention of smoking in younger girls by looking towards future pregnancies.

c. Plan for the Coming Year

- Partnerships will continue with DMAP, local providers and agencies in training, information, and education on the 5 A's protocol and the 2008 revised DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.

- Cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC will continue during 2010.

- Evaluation of county client data reports from ORCHIDS will improve surveillance and monitoring on tobacco exposure during pregnancy and provider interventions. The information will be used by the Perinatal Title V Program to plan for strategies in program services delivered by county health department partners.

- The Preconception Health Action Plan will continue planning and implementation of public health programs that address smoking prevention and cessation as it relates to future pregnancies of clients of health department partners.

- As part of the "Preconception Health" perinatal initiative the Office of Family Health was awarded the Health Resources and Services Administration (HRSA) grant, "First Time Motherhood". This project will address issues prior to the first pregnancy and continuing through subsequent pregnancies in our Latina immigrants' second generation population. Currently, the project is in the final stages of contract development for the "Passing on Strengths" campaign.

State Performance Measure 3: *Percent of infants diagnosed with hearing loss that are enrolled or in Early Intervention before 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			53.4	54	54
Annual Indicator		40.7	34.7	49.2	53.8
Numerator		24	25	29	21
Denominator		59	72	59	39
Data Source					Oregon EHDI Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	56	57	58	58

Notes - 2008
2008 marks the first time that more than 50% of infants diagnosed with hearing loss were enrolled in early intervention before 6 months of age. However, this measure should be interpreted with caution as both the numerator and the denominator are relatively small, making the measure prone to fluctuation.

Notes - 2007
Source: Oregon EHDI Program

Notes - 2006
EHDI referred a total of 81 infants to EI. Of those, 38 enrolled in EI by six months of age, six enrolled between six and 12 months of age, 17 did not enroll, and 20 had an unknown enrollment status. Of the 17 infants who did not enroll in EI, five were not eligible for the program due to normal hearing (4) or due to unilateral/mild loss (1), two moved out of Oregon, seven families refused the services, and three were lost to follow-up. Excluding the seven infants who were not eligible for the program or moved out of the state, the rate of enrollment by six months of age was 51% (38/74).

a. Last Year's Accomplishments

Note on the data: 2008 marks the first time that more than 50% of infants diagnosed with hearing loss were enrolled in early intervention before 6 months of age. However, this measure should be interpreted with caution as both the numerator and the denominator are relatively small, making the measure prone to fluctuation

- EHDI worked to develop parent support networks for parents who have children with hearing loss. The program established a parent mentoring program for parents of infants with hearing loss. EDHI hired a parent coordinator to communicate with families and help train parent mentors throughout the state. Additional resources for parents were developed including a new family resource guide for parents who have children with hearing loss, parent brochures, and DVD's demonstrating different communication options.

- Through a collaborative partnership with midwives and stakeholders, EHDI was able to establish four free hearing screening clinics to address the out-of-hospital birth population as well as smaller non-mandated hospitals.

- Ongoing data collection and referrals were made on infants needing follow up and services for hearing loss. EHDI worked closely with diagnostic audiology centers and early intervention programs to ensure timely diagnosis and enrollment in early intervention for infants with hearing loss. The EHDI Advisory Board met quarterly and revised Early Intervention referral protocols to include unconfirmed loss. The EHDI Program continued to send status reports to each county Part C program to monitor the status of infants referred to EI for hearing loss.

- A Parent Satisfaction survey was conducted to evaluate Early Intervention Programs throughout the State. The survey results emphasized the need for the Parent mentoring program in addition to early intervention services.

- EHDI staff continued to contact families, medical home providers and local public health to assist families in navigating the system. Referrals to Oregon's Children with Special Health Care Care Coordination (CaCoon) nursing program will continue for all infants identified with hearing loss.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnerships with Department of Education/EI programs to improve referral and eligibility process				X
2. Educate primary health care providers about the importance of timely early intervention services				X
3. Maintain an update list of Early Intervention programs and provide to diagnostic centers and health care providers				X
4. Increase referrals to Children with Special Health Care Needs Nursing Program to assist families in receiving timely intervention services		X		X
5. EHDI Program will continue to be single point of referral for birth to three year olds with hearing loss to Early Intervention programs		X		
6. Improve Parent-to-Parent Support for parents with children with hearing loss.				X
7.				
8.				
9.				
10.				

b. Current Activities

- The EHDI Program continues to: ensure that infants with hearing loss are enrolled and receiving EI services before 6 months of age; make EI referrals directly to Part C for infants diagnosed with hearing loss; send reports to EI programs regarding the status of infants referred to their program.

- EHDI is currently working with Pacific University to establish an audiology degree program in Oregon projected to begin in 2012. The establishment of this program will help address the shortage of pediatric audiologist and the lack of this degree program in the State.

- The EHDI Program continues to operate its loaner hearing aid bank, providing easy access to loaners for all infants birth to three years of age who are enrolled in EI Programs.

c. Plan for the Coming Year

- EHDI is working with the audiology Best Practices subcommittee to sponsor pediatric audiology trainings. The trainings will focus on pediatric audiology practices to ensure that appropriate testing is conducted and to cultivate individuals throughout the state proficient in the necessary diagnostic testing methods.

- The EHDI Parent Program plans to train and hire parent guides throughout the State to support and mentor parents who have children that have been diagnosed with hearing loss. This program aims to reach out to the rural communities to expand the level of service, information, and technology available to them and their children.

- EHDI plans to improve access for the uninsured population that is not able to get the necessary diagnostic testing. A part time audiologist is being hired to travel to rural counties and serve the uninsured population as well as training local audiologist to perform the testing.

- EHDI is working with the Oregon Lions Sight and Hearing Foundation to pilot a mobile infant screening unit. If the project proves successful EHDI and the Oregon Lions may look at equipping existing mobile units to be able to perform diagnostic testing.

State Performance Measure 4: *Percent of children that complete the 4th DTaP vaccine between 12 and 18 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			68.5	69	69.5
Annual Indicator	66.4	65.1	65.7	66.2	66.2
Numerator					
Denominator					
Data Source					National Immunization Survey, 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70.5	70.5	71	71

Notes - 2008

No significant change has occurred in the 4th DTaP completion rate of among Oregon 12 to 18 month old children. 2008 data is not available.

Notes - 2007
National Immunization Survey, 2007 data; survey does not report numerators and denominators.

Notes - 2006
Source: 2006 National Immunization Survey

a. Last Year's Accomplishments
Note on the data: No significant change has occurred in the 4th DTaP completion rate of among Oregon 12 to 18 month old children. 2008 data is not available.

- Disseminated print materials (posters, rack cards) at OPIC coalition meetings and statewide conferences and partner meetings.

- Maintained information on the OPIC website for the "Focus on the 4th DTaP Campaign", a joint Oregon-Washington childhood pertussis immunization campaign. The campaign included parent materials, provider materials, radio and TV PSAs and billboards. http://www.oregon.gov/DHS/ph/imm/opic/fourthDTaP.shtml

- Guidance for local health departments to assist their annual planning efforts on improving 4th DTaP rates in their communities.

- Promoted 4th DTaP as one strategy to improve pertussis prevention across the lifespan. Promotion efforts include: radio PSAs and on-air interviews targeting African American parents and grandparents (25-54); television PSAs in English and Spanish through targeted programming on local cable access; and written information for parents and providers posted to our website.

- Provided free adult/adolescent pertussis vaccine (tdap) to adults to protect vulnerable community members.

- Concluded evaluation of parent reminder/recall interventions to identify which methods and timing might increase uptake of timely 4th DTaP.

- Coverage for the fourth DTaP dose is the lowest among primary childhood vaccines while Pertussis is increasing in Oregon. We partnered with Acute and Communicable Disease Program to assess the incremental effectiveness of the fourth DTaP dose in preventing pertussis and found that it did not offer additional protection among Oregonians. Additional research is needed to determine if it lessens disease severity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Communication Network established between Oregon and Washington state coalitions to share immunization information			X	X
2. Educational materials distributed through Communication Network and posted to websites			X	X
3. 4th DTaP multimedia campaign in Oregon and Washington – radio, tv, billboards			X	
4. Local health departments using state funding to build on 4th DTaP in their communities – billboards, special outreach, special recalls	X		X	
5. Educational materials provided to Oregon SafeNet (211Info)		X	X	

on 4th DTaP campaign.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program will:

- Continue working with local health departments and private providers to focus quality improvement efforts on increasing the timely administration of 4th DTaP. The Immunization Program leads this process by completing immunization assessments that measure up-to-date rates and clinic practices that affect those rates.

- Partnering with DHS Communications Office to promote pertussis prevention through articles, fact sheets, educational materials and speaking opportunities on the family and community impact of pertussis.

- Continue to provide population-based immunization rates to counties and partners to assess timely administration of 4th DTaP and other vaccines.

- Disseminate educational materials and current literature at OPIC coalition meetings, statewide conferences and partner meetings.

- Partner with DMAP to assess missed opportunities for 4th DTaP administration among children enrolled in their program.

c. Plan for the Coming Year

- Plans include implementation of the new Immunization Information System that will combine ALERT and IRIS registries, to improve support for providers.

- Immunization Program will continue to provide assessment data, technical assistance, and financial resources to support LHD outreach and private provider increased rates of 4th DTaP vaccines.

- Immunization and OPIC will continue to partner with community groups to communicate the impact of pertussis on families and communities and to ensure that all children have the opportunity to complete the DTaP immunization series.

State Performance Measure 5: *Percent of 8th graders who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			75	75	70
Annual Indicator		59.0	59.0	56.2	58.3
Numerator		9063	2094	5016	6091

Denominator		15363	3550	8928	10441
Data Source					Oregon Healthy Teens Survey (YRBS) 2008
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73	75	75	75	75

Notes - 2008
The numerator and denominator are not weighted in this table and represent the number of respondents, not the total population. Oregon Healthy Teens Survey (Oregon's Youth Risk Behavior Survey) is based on weighted percentages.
- For 2005, the correct numerator and denominator are 4,904 and 8,433 respectively. The weighted percentage is 57.9%.
- For 2006, the weighted percentage is 59.5%.
- For 2007, the weighted percentage is 55.7%.
- For 2008, the weighted percentage is 58.0%.

Notes - 2007
Source: Healthy Teens Survey, 2007.

Notes - 2006
Source: Healthy Teens Survey (YRBS), 2005

a. Last Year's Accomplishments
Note on the data: Oregon Healthy Teens Survey (Oregon's Youth Risk Behavior Survey) is based on weighted percentages. The data in this table represent the unweighted data. The weighted data trends have been stable between 2005-2008, ranging from a low of 55.7% in 2007 to a high of 59.5%.

- Representatives from each section in the Office of Family Health (OFH) met to coordinate messages and activities around nutrition and physical activity within OFH programs. They also provided input into legislative proposals for obesity and diabetes prevention in Oregon.

- 168 Oregon schools and over 13,901 children and parents participated in Walk and Bike to School Day.

- Represented public health in Safe Routes to meetings and planned 2007 Walk and Bike to School Week in October.

- Coordinated efforts with Healthy Kids Learn Better (HKLB), Alliance for Healthier Generations and Oregon's Action for Healthy Kids Team to assist schools in assessing and implementing their School Wellness Policies -- including policies around PE, recess, and walking and biking to school.

- Continued the partnership with Physical Activity Network, Kaiser Permanente, Oregon PTA, Multnomah County Libraries and the NW Media Literacy Center, Community Health Partnerships, OSU Extension and YMCA to sponsor Oregon's TV-Turnoff Week. The coalition staged and publicized a variety of events during the week, attracting participants throughout Oregon and SW Washington. In preparation for the event, the coalition published a wide variety of print media regarding TV-Turnoff Week and the potential effects of excessive screen time. Representatives from OFH contributed to the creation, promotion and distribution of more than 20,000 copies of TV-Turnoff and Screen Time Awareness materials, including a flyer created by several OFH members titled, "You Have the Power: 5 Steps to Guide Your Child's TV Time".

- Worked in collaboration with the Oregon Physical Activity and Nutrition (PAN) Program which is housed within the Office of Disease Prevention and Epidemiology -- until they lost their grant in

7/08. The OFH Physical Activity and Nutrition group continues to work with the Office of Disease Prevention and Epidemiology (ODPE) Physical Activity Network (PAN) program to continue efforts around physical activity.

- Physical activity messages are a routine part of SBHC visits. The School-based Health Center program (SBHC) continued to develop goals on obesity prevention, physical activity and nutrition and BMI measurements.

- The State WIC Program recommended a physical activity objective for WIC locals in local nutrition education plans. WIC worked to incorporate messages around physical activity into their one-on-one nutrition counseling.

- OFH worked to provide resources on physical activity and nutrition to child care. For parents of young children, home visiting public health nurses promoted physical activity messages to promote growth and development, such as infant tummy time and appropriate screen time.

- Family Planning and Women's Health programs made physical activity and nutrition materials available on their website. The Immunization program participated in TV-Turnoff Week by handing out promotional stickers through local immunization clinics.

- Local public health nurses taught parents activities to promote growth and development in their children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate Nutrition and Physical Activity across the Office of Family Health Programs, and Worksite Wellness Activities				X
2. Provide leadership and coordination of Walk and Bike to School Day for communities				X
3. Collaborate with Safe Routes to School programs				X
4. Assist WIC and Child Health with promoting TV-Turn Off Week and distributing materials				X
5. Assist WIC and Child Health programs provide education on limiting screen time				X
6. Compile and analyze state-level physical activity data from a variety of sources				X
7. Promote family-centered physical activity promotion activities when possible in state and local programs and policy efforts				X
8. Support population-based planning and policy efforts to include adequate daily physical activity.			X	
9. Support school staff in adopting and implementing school wellness policies that focus on physical activity within the school day		X		
10.				

b. Current Activities

- OFH Nutrition and Physical Activity Workgroup meets monthly to integrate physical activity and nutrition messages into OFH programs.

- OFH is working in collaboration with ODPE to promote legislative policies based on the physical activity strategies listed in the statewide physical activity and nutrition plan.

- Walk and Bike to School Day: OFH programs are planning the 2009 WBTS Day and May Challenge Month and encouraging year round walking and biking.

- Healthy Kids Watch Less TV: OFH participates with the state-wide coalition.

- OFH is working to get information on physical activity and nutrition out to child care providers.

- School-based Health Centers continue to give messages about physical activity.

- Home visiting public health nurses promote physical activity messages.

- The Immunization program participated in 2009 TV-Turnoff Week by handing out promotional stickers through local immunization clinics. WIC developed activity cards to give to participants.

- Continue to represent Public Health on Safe Routes to School Committee.

- Youth Action Research Project in process this year. Nutrition and Physical Activity research topics. Students chose to research barriers to eating school breakfast and lunch for students and school staff.

- Working in collaboration with other agencies to help schools implement school wellness policies and improve nutrition and opportunities for physical activity within the school environment.

c. Plan for the Coming Year

- OFH Nutrition and Physical Activity Workgroup: Representatives from each section in the Office of Family Health (OFH) will continue to meet and work on coordinating consistent messaging around physical activity and nutrition and integrating these messages into all OFH programs. This group will continue to work to identify strategies listed in the recently released Oregon Physical Activity and Nutrition Plan 2007-2012 that can be incorporated into OFH programs' activities.

- Safe Routes and Walk and Bike to School Day: OFH programs will assist with planning the 2010 Walk and Bike to School Day, May Challenge Month and promote walking and biking activities throughout the year.

- OFH will continue to collaborate with the Safe Routes to School programs.

-Healthy Kids Watch Less TV: Continue to participate in state-wide coalition, promote the importance of limited screen time for children and families, disseminate our "You Have the Power" handouts, and plan for 2010 TV-Turnoff Week with partners.

- OFH Programs: Continue to integrate physical activity messages and activities into OFH programs. Continue to utilize physical activity data, including the new Elementary School Survey and exploring new avenues of collecting needed data.

- Continue to develop our working relationship with the Oregon Childcare Resources and Referral Network (CCRRN) and get information about physical activity and decreased sedentary activity out to the public. Look for opportunities, like the United Girls' Summit, to promote and educate on the importance of physical activity. Continue to work with groups like WISE to ensure that School Wellness policies and evaluative monitoring systems are in place.

- Continue to participate in worksite wellness activities in PSOB and work on bringing more activities and policy decisions to OFH. Continue working with partners and promoting activities that promote physical activity and an active, healthy life for Oregonians.

- Statewide Nutrition and Physical Activity Plan: Continue our partnership with the the Chronic Disease program to promote strategies listed in the state plan that address the environments in which Oregonians spend their time and support physical activity in each socio-ecological level.

State Performance Measure 6: *Percent of 11th graders who report having unmet health care needs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	29	29
Annual Indicator		33.5	28.1	28.6	27.7
Numerator		3527	724	1654	1942
Denominator		10529	2576	5783	7001
Data Source					Oregon Healthy Teens Survey (YRBS) 2008
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	28	27	26	26

Notes - 2008
Oregon Healthy Teens Survey (Oregon's Youth Risk Behavior Survey) is based on weighted percentages; numerator and denominator are not weighted and represent the number of respondents, not the total population. Because of the change in survey question text between 2005 and 2006, there is a break in interpretable trend data. Between 2006 and 2008, the rate has been essentially unchanged, hovering around 28%.

- For 2005, the correct numerator and denominator are 2201 and 6676 respectively. The weighted percentage is 33.5%.
- For 2006, the weighted percentage is 28.1%.
- For 2007, the weighted percentage is 28.9%.
- For 2008, the weighted percentage is 27.8%.

Notes - 2007
Source: Healthy Teens Survey, 2007.

Notes - 2006
Source: Healthy Teens Survey (YRBS), 2005.

a. Last Year's Accomplishments
Note on the data: Because of the change in survey question text between 2005 and 2006, there is a break in interpretable trend data. Between 2006 and 2008, the rate has been essentially unchanged, hovering around 28%.

- The CDC Cooperative Agreement that supported the Office of Family Health in conjunction with the Health Promotion and Chronic Disease Prevention Program worked together to continue a focus and maintain a public health led Coordinated School Health Program. The Program supports the following activities:

- $300,000 was leveraged through a partnership with the Oregon Addictions and Mental Health Division to continue and refine the Healthy Kids Learn Better- Mental Health Demonstration Project.

- Participation and leadership nationally to further the development of utilizing the Coordinated School Health Approach to address mental health. The National Assembly on School Based Health Care is a critical partner in this work.

- Development of a partnership and a contract which supports the provision of health education professional development for educators.

- Revisions and refinements to the School Mental Health Inventory Tool.

- Administration of the 2008 Center for Disease Control and Prevention's School Health Profiles Survey.

- Eighteen SBHC planning sites (in 12 counties) were awarded Phase I funds to plan and develop a SBHC in their community. Five of the sites were in counties without existing SBHCs.

- The SBHC program conducted a workgroup to re-evaluate and revise SBHC certification standards.

- The SBHC program implemented compliance with a set percentage of key performance measures in all certified SBHCs. A revised KPM technical assistance tool was presented to all SBHCs.

- A Public Health Nurse position was added to the SBHC program.

- Two needs assessment projects completed:
  - Expansion of SBHCs;
  - Health services provided at Oregon Community Colleges.

- The Adolescent Health program piloted an evaluation of the adolescent well-visit booklets with a local independent physician's association. We collected data on parental opinions of the booklet, as well as whether parents were more likely to schedule a well visit for their youth.

- Adolescent Health staff participated in the governance group for the Oregon Healthy Teens (OHT) survey and on content, financing and general governance committees to ensure appropriate measures are included in the survey related to unmet physical and emotional health needs.

- Adolescent Health collected and analyzed data related to youth (8th grade) lifetime participation in and awareness of the Choking Game. This is an area where almost no scientific, quantitative prevalence data exists. Staff drafted a paper for journal submission on the results.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Infrastructure funding and support for School-Based Health Centers				X
2. Technical assistance, training and funding for local School-Based Health Center planning				X
3. Support and technical assistance to build sustainability of local School-Based Health Centers				X
4. Consultation and technical assistance to assure certification of School-Based Health Centers				X
5. Data collection and evaluation of School-Based Health Center				X

clients and visits				
6. Infrastructure funding for coordinated school health programs – Healthy Kids Learn Better (HKLB)				X
7. Technical assistance and planning with HKLB school sites				X
8. Data collection and evaluation of Coordinated School Health programs				X
9. Conduct the Oregon School Health Policy & Programs Survey				X
10. Participate on the Oregon Health Teens Survey (YRBS) Governance Group				X

b. Current Activities

- OFH collaborated with the Health Promotion and Chronic Disease Prevention Program to maintain a public health focus for the Coordinated School Health Program. The Program supports the following activities:
- Leadership, training, and technical assistance to support implementation of a mental health focused Coordinated School Health Program
  - Data gathering for the 2008 CDC's School Health Profiles Survey.
  - Analysis of data to examine correlations between youth gambling behaviors and other health risks.
  - Creation of an evaluation plan to examine the impact of school participation in Coordinated School Health with youth tobacco use rates.

- Twelve School-Based Health Centers planning sites advanced to Phase II with the expectation of being state certified by June 30, 2009; three of the twelve sites are in counties without existing SBHCs. Eleven new certified SBHCs opened.

- The SBHC Program and partners participated in a workgroup to reevaluate the current State funding formula, for recommendation to the Conference of Local Health Officials (CLHO).

- The Adolescent Health program is writing and submitting a paper on youth Choking Game participation to the MMWR journal for review.

- Adolescent Health is working on a pilot of collecting information about positive youth development indicators from youth-serving programs around the state and will evaluate for statewide roll-out.

c. Plan for the Coming Year

- Healthy Kids Learn Better will continue partnering with the Health Promotion and Chronic Disease Prevention Program on the Tobacco Related and Other Chronic Disease Initiative. This initiative is designed to increase local public health capacity to address chronic disease prevention, early detection, and self-management across schools, communities, health systems, and work sites. HKLB will provide training support related to working with schools utilizing a coordinated school health approach.

- Continue support of the North Clackamas Mental Health Project

- Continue development of the Healthy Kids Learn Better- Health Education Cadre

- Implementation of revised SBHC Certification Standards.

- The SBHC program will continue to collect and maintain a statewide medical encounter and operations database to monitor, evaluate and report on SBHC services and utilization.

- The SBHC program will continue to use information from the Mental Health Needs Assessment

Project and work with partners to provide technical assistance, training and system development in the area of emotional health.

- - The SBHC program will implement a new funding formula.

- The SBHC program will continue to monitor progress of key performance measures in all certified SBHCs.

- With 2009 Legislative approval of the Healthy Kids Plan including funding for SBHCs, the SBHC program will be able to focus on expansion and sustainability of the SBHC model. The expansion of the SBHC system into new and existing counties will increase access to 3,000-7,000 additional students. The sustainability component will focus on an increase in the funding base to improve SBHC capacity and provide mental health services and/or improve surveillance of mental health services through implementation of quality assurance measures, such as data reporting and referral monitoring.

- The SBHC program will work to implement positive youth development into state and local SBHC programs and participate in the state PYD Alliance.

-SBHC Certification will be revised to span the biennium and will be conducted by one individual to facilitate continuity and standardization of site visits and to reduce costs.

- The SBHC program will review results from the SBHC mental health referral system survey.

- The SBHC program will conduct an assessment of local public health authorities (LPHAs) regarding SBHC expansion in 2011-13.

- Adolescent Health will continue to work on advancing a policy proposal to extend health insurance coverage to older adolescents (age 18-25) by extending the age at which they are considered dependents, for insurance purposes, and allowing them to remain on parental coverage. We have acquired a graduate intern who will be coordinating this process.

State Performance Measure 7: *Percent of Oregonians living in a community where the water system is optimally fluoridated.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	27	27	28	21	21
Annual Indicator	20.3	20.3	27.4	27.4	27.4
Numerator	728469	737549	839727	839727	839727
Denominator	3582600	3631440	3069204	3069204	3069204
Data Source					Oregon Drinking Water Program
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	21	21	21	21

Notes - 2008

Oregon Drinking Water Program supplied by the Oral Health Program to CDC's/ASTDD's Water Fluoridation System.

Numerator: Population receiving optimally fluoridated water, including naturally fluoridated water
Denominator: Population served by public water systems

Data is not available for 2008 so continue to use 2006 data. Availability depends on how often the Drinking Water Program gets data from public water systems.

Previously reported data for 2004, 2005, and 2006 were incorrect. The correct percentages are 18.8% for 2004 and 2005 and 27.4% for 2006.

Notes - 2006
The projection is based on an increase in population, not a decrease in the number of communities with fluoridated water.

The objective target is adjusted to 21% for 2006.

a. Last Year's Accomplishments
Note on the data: Oregon Drinking Water Program supplied by the Oral Health Program to CDC's/ASTDD's Water Fluoridation System. Numerator: Population receiving optimally fluoridated water, including naturally fluoridated water/ Denominator: Population served by public water systems. Data is not available for 2008 so continue to use 2006 data. Availability depends on how often the Drinking Water Program gets data from public water systems.

- Despite losing funding from the CDC, the Oral Health Program continued efforts to enhance the infrastructure and capacity for optimal water fluoridation; provide technical assistance across Oregon on community water fluoridation; and establish and support existing community coalitions that will advocate for optimally fluoridated water.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocate for community water fluoridation through public education and policy development				X
2. Establish and provide technical assistance in the development of community coalitions				X
3. Collaborate with Oregon Drinking Water Systems to provide technical assistance to water districts			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
- The Water Fluoridation Reporting System (WFRS) is a national database operated by the CDC. It allows users to look at fluoride information by water system in a state.

- The Oregon Oral Health Coalition (OROHC) has established a new committee, Education and Promotion, as a result of a strategic planning process sponsored by the Northwest Health Foundation. The aim of the new committee is to identify the primary messages that OROHC supports, with water fluoridation being a primary component.

- The Oral Health Program coordinated with the CDC to bring their National Fluoridation Engineer to speak to the Oregon Drinking Water Program.

c. Plan for the Coming Year

- In collaboration with the DHS Drinking Water Program (DWP), the Oral Health Program will continue to maintain Oregon data in the CDC Water Fluoridation Reporting System (WFRS).

- The Oral Health Program will continue to provide technical assistance to local communities on technical and preventive aspects of fluoridating community water systems.

- The Oregon Oral Health Coalition will continue to collaborate with the Healthy Smiles coalition in support of community water fluoridation.

State Performance Measure 8: *Percent of health care providers who report confidence in caring for CYSHN and their families*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	94	95	95	95	96
Annual Indicator	97.7	91.7	95.1	95.1	90.6
Numerator	130	166	137	137	164
Denominator	133	181	144	144	181
Data Source					OCCYSHN-administered training satisfaction surveys
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	96	98	98	98	98

Notes - 2008

As described in the 2007 Notes, in 2008 we implemented a new method for measuring provider confidence in caring for CYSHN. As a component of our post-training evaluation activities, we are asking providers who attend OCCYSHN-offered trainings to respond to a single survey item that asks they indicate the extent to which the training they attended improved their confidence in caring for CYSHN. The following response options are provided for this question: Strongly Agree, Agree, Disagree, Strongly Disagree. The denominator for this indicator (n = 181) represents the number of individuals who attended the 14 trainings offered by OCCYSHN during FY 2008. The numerator for this indicator represents the number of individuals who indicated that they Strongly Agree (n = 46) or Agree (n = 107) that the training activity improved their confidence in caring for CYSHN (n = 164).

While we feel that the method we implemented for 2008 provides us with a better approximation

of the degree to which OCCYSHN training activities are contributing to progress toward this indicator, we are currently investigating other methods that will allow us to more globally assess the degree to which the broader health care provider community is confident in caring for CYSHN . We are currently reviewing options for using existing measures and the potential for creating a new measure to capture the concepts underlying the latent construct of confidence.

Note on data: An overwhelming majority of providers who participated in OCCYSHN-sponsored trainings during the prior fiscal year (84.5 percent) indicated that the training(s) in which they participated improved their confidence in caring for CSHCN.

Data Source: Data used to compute this indicator are from OCCYSHN-administered training satisfaction surveys. Surveys are administered following each training provided by OCCYSHN.

Notes - 2007
This represents a proxy measure of confidence. This is the number of providers trained of those "available" in the program year to train, including CaCoon Coordinators (45), Promotoras (4), community members of the Community Connections Network (42), CDRC clinicians (35), LEND Trainees (12) and our Family Liaison (6). Of the 144 providers who were availabe to receive training by OCCYSHN, 135 participated in training activities.

OCCYSHN is working to develop a measure of confidence of providing care to CYSHN.

The numbers reported for 2006 and 2007 are identical due to the fact that we inadvertently reported 2007 data in 2006. In 2008 we have begun to implement a survey item asking trained providers to indicate the extent to which they are confident in the care of CYSHN and their famlies.

Notes - 2006
This represents a proxy measure of confidence. This is the number of providers trained of those "available" in the program year to train, including CaCoon Coordinators (45), Promotoras (4), community members of the Community Connections Network (42), CDRC clinicians (35), LEND Trainees (12) and our Family Liaison (6). Of the 144 providers who were availabe to receive training by OCCYSHN, 135 participated in training activities.

OCCYSHN is working to develop a measure of confidence of providing care to CYSHN.

a. Last Year's Accomplishments
- OCCYSHN ensured a confident and competent workforce through its statewide training program. Ongoing training and supports continued for PHNs, CCN teams, and Family Liaisons (FL). Over 300 training contacts were made in FY08.
- OCCYSHN participated in the CDRC Grand Rounds providing training to OHSU, CDRC, OIDD and OCCYSHN faculty, clinicians and staff on topics related to systems of care for children with special health needs.
- CaCoon oriented 5 new public health nurses (PHNs) and conducted 34 annual site visits to monitor services in relation to program standards and to provide consultation, TA, onsite training. CaCoon PHN training topics included statewide data collection/reporting system , TCM, and orientation to the revised CaCoon Manual.
- Center Family Consultants (FCs) continued work with CCN teams and FLs on partnerships and family input and provided training to each team with an FL member on integrating family perspective.
- OCCYSHN hosted a CCN training: "Strong Teams, Strong Communities" for team members, FLs and CaCoon PHNs addressing HIPAA, updates to CCN Manual, Family Partnership and community engagement. 28 updated CCN Procedural Manuals were distributed to14 CCN Teams.
- OCCYSHN sponsored a statewide conference "Celebrating Oregon's Communities" in partnership with the OFH, training 215 MDs, PHNs and family members and other providers and

state agency participants on topics related to medical and system of care. 86% of participants reported high satisfaction and that it would assist them in their work; 12 FLs participated and reported an increase in knowledge and confidence in their roles.
- The Oregon Pediatric Society, OCCYSHN and local hospitals partnered on 5 regional trainings on ASD/Autism screening tools for 112 health care providers statewide.
- Community Consultants and partners provided 18 in-service and/or consultations addressing ASD, ADHD, and behavioral health including adolescent depression, TBI, and eating disorders.
- OCCYSHN staff presented at the 2008 "Partnerships between Education & Medicine" Event in central Oregon to increase understanding of MCH and OCCYSHN health systems and programs. 50 teachers, physicians, and other providers attended.
- 100 program, CDRC and other OHSU staff participated in the Center training by Dr. Tom Wolff on building coalitions for healthy communities. Dr. Wolf led a strategic planning session for improving Oregon systems of care for CYSHN.
- OCCYSHN staff provided 6 training sessions to LEND trainees addressing Health Care Systems, Family Centered Care, Family Resources, Adolescent Transition, Evidence-Based Medicine and Families, Disability Law & Learning Disabilities.
- Screening Learning Collaborative (SLC) continued in 5 rural communities resulting in an increase in screening of young children. OCCYSHN sustained TA support and connections with the teams. Key informant interviews and evaluation surveys indicated a positive increase in screening at the community level, one community indicating their screening rate increased 25%; 3 teams highlighted their screening improvement projects at the 2008 OCCSYHN Conference.
- OCCYSHN partnered with the OFH and other key state collaborators in the Oregon ABCD Screening Academy to increase screening, referral, identification, and follow up for young children at risk for developmental delays, behavior, social or emotional challenges.
- Alternative methods of delivery of training, including videoconferences (SLC), web conferences, telemedicine (Genetics) and/or regional trainings (CaCoon Manual) were piloted and evaluated; web conferences were reported to be the most successful.
- OCCYSHN evaluated information/training needs of both families and providers via paper and online survey methods at the CCN Fall Training and throughout the year. OCCYSHN developed a pre/post test for public health nurses to complete after orientation to the CaCoon Program.
- A variety of evaluation tools and methods for evaluating family experiences and satisfaction with services provided by OCCYSHN trained providers were explored. Efforts to develop a new method to evaluate parents' and providers' confidence in caring for CYSHN were interrupted by staff changes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and technical assistance for providers of CYSHN through a variety of venues and formats.				X
2. Develop and provide training to Family Involvement Network; support leadership training for families.				X
3. Partner with agencies/associations to include topics of chronic conditions/special health needs on training agendas.				X
4. Disseminate information on evidence-based best practice/promising practices.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Continue development of CYSHN curriculum for PHNs. Pilot the partially completed CYSHN module. Provide ongoing training and TA support to CaCoon sites including annual site visits and county specific TA.
- Provide orientation training and ongoing support to FLs. FCs continue to meet with FLs via webinar and personal contact as well as phone contact.
- Provide at least one local In-service training or consultation for each CCN community. CCs provide in-service or consultation. CCN Consultants and partners work with local hospitals to offer providers Grand Round CMEs. Begin development of CCN toolbox to increase access to resources, tips and promising practices link CCN toolbox to OCCYSHN website.
- Provide distance training in partnership with LEND and CDRC providers to local providers statewide. Continue trainee training activities in partnership with LEND.
- Participate in Oregon ABCD Screening Academy to increase identification, treatment, and follow up for young children.
- Collaborate with ODE ECS to train primary care and tertiary care providers on use of universal referral form to Early Intervention/Early Childhood Special Education.
- FCs partner with family groups to share information and give input on services available in the state including DD council, FVs, OrPTI, Special Olympics; and with Disability Compass, FACT, F2F, OrPTI and other family groups to promote FPPs, medical home and family centered care.
- Pursue improved evaluation methods and tools.

c. Plan for the Coming Year

- OCCYSHN will continue its training program at a reduced level of funding to meet the knowledge and skill needs for local providers and families around the state.
- OCCYSHN will continue to develop the CCN toolbox such that it supports best practices for community-based services and systems of care improvements. Input of a variety of professional experts will be solicited to support best practice.
- OCCYSHN will explore opportunities to partner with LEND program on distance training targeted for Lincoln County to increase rural provider confidence and competence in caring for CYSHN.
- Explore the development and delivery of a 2 day training for providers, educators and families in Klamath Falls to adderss their needs relative to ADHD diagnosis, treatment and medical management.
- OCCYSHN staff will participate in community forums and educational events, either as leaders or as participants to share expertise and gather information with and for families and providers.
- OCCYSHN will continue to support a physician hot line.
- OCCYSHN will continue to develop its' website so that families and providers can easily locate needed information and tools. OCCYSHN will work with Disability Compass to continue to develop that on line resource tool.
- Facilitate webinar trainings on CYSHN topics pertinent to primary care and other providers. Archive the trainings and save for future training use.
- Continue OCCYSHN Nurse Consultant support for county CaCoon PHN's.
- Explore presentation of CaCoon and LHDs promising and Evidence-Based practices at AOPHNS conference.
- Complete PHN Care Plans for Initial Assessment and On-Going Plan of Care for CYSHN. Disseminate and monitor implementation.
- Provide distance learning events targeted to local PHNs through webinars.
- Explore partnership with OPS to develop training addressing the needs of local physicians around medical home and the diagnosis and intervention with autism.
- Include CDRC specialty care providers in OCCYSHN events and planning.
- Continue to provide training to LEND trainees as contribution to workforce development on behalf of children with special health needs.
- Provide developmental pediatric consultation and training to frontier and rural providers working with children with special health needs.
- Engage rural and frontier pediatricians in partnership with the OPS's Committee on Children with Disabilities in intensive training around medical home practices as they support CYSHCN.

- In partnership with LEND, increase local provider capacity within rural and frontier communities through locally provided training and consultation.

State Performance Measure 9: *Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			65	65	86
Annual Indicator		62.3	62.3	85.5	85.5
Numerator		70694	70694	99990	99990
Denominator		113418	113418	116988	116988
Data Source					2005/06 NS-CSHCN
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	90	90	90	90

Notes - 2008
As in 2007, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator.

Note on data: Of the 85.5 percent of Oregon families who indicated costs not covered by insurance were either usually or always reasonable, nearly half (48.4 percent) indicated that these costs were usually reasonable and slightly more than half (51.6 percent) indicated these costs were always reasonable.

Data Source: Data used to compute this indicator are from the 2005/06 NS-CSHCN. The specific item used to compute this information is C8Q01_B, as follows: “Are the costs not covered by (child’s name) health insurance reasonable? Response options for this item are Always, Usually, Sometimes, and Never.

Notes - 2007
This year's report of State Performance #9 is derived from item C8Q01_B of the NS-CSHCN for 2005/2006. There is a slight variation in the item from the 2001 survey in that the response option "No out of pocket costs" was added which 7.9% of Oregon respondents selected.

Notes - 2006
2006 data not available; data from 2005 is carried forward.

a. Last Year's Accomplishments
-The Family Support Program (FSP) processed 985 funding requests in FY08 and served 716 children. This is an increase over the number of requests and children served documented in FY07 (923 requests and 692 children, respectively) with approximately the same budget ($275,000). FSP staff coordinated funding, processed purchase orders and managed the Zetosch endowment fund that provides financial assistance to families for educational products and services. The annual FSP budget was fully spent by the end of April 2008. An advisory group, including OCCYSHN staff, specialty and community providers assisted in FSP planning and decision-making.
-OCCYSHN staff reviewed data from the 2005-2006 NS-CSHCN related to out of pocket costs and disseminated to families, partners, and policy-makers.
-OCCYSHN analyzed and tracked telemedicine policy issues and legislative health care reform

concepts and activities as they impact health care finance issues. Updates were provided to families, providers and partners in the OCCYSHN newsletter. Staff developed other educational print materials pertaining to access to health insurance. Impacts of proposed legislation on CYSHCN and their families were shared with Office of Family Health and other state groups.
-The Spring 2008 OCCYSHN Annual Conference addressed health care finance topics including Medicaid reimbursement for genetic services, guardianship, developmental and behavioral screenings and impacts of historical and current health reform efforts on CYSHCN. The Division of Consumer and Business Services of the Insurance Commission provided a poster at the poster session.
-OCCYSHN partnered in the ABCD Screening Academy resulting in clarification of OHP coding and reimbursement and improved linkages with Early Intervention programs.
-OCCYSHN engaged in discussions with DMAP around Oregon Health Plan consumer protections for people with disabilities, CYSHCN and their families.
-OCCYSHN assisted DMAP in implementing genetic services policies and monitoring utilization of genetic services.
-OCCYSHN continued its partnership with the Oregon Health Services Commission related to coverage of services under the OHP and staffing its Genetics Advisory Committee.
-OCCYSHN continued its financial support of community-based services to families through CaCoon, CCN and FSP and made efforts to identify additional funding sources for meeting family needs not covered by insurance.
-OCCYSHN identified information sources on family costs for care, insurance denials, and successful appeals.
-OCCYSHN partnered with Oregon's Family-to-Family Health Information and Education Center to explore opportunities for cross-training Family Liaisons to provide additional information and navigational supports to families within CCN catchment areas.
-Due to changes in program staff, OCCYSHN was unable to conduct the planned survey of families' regarding needs and barriers to care. In lieu of this activity, analyses were conducted using data from the 2005/06 NS-CSHCN to inform partners regarding out of pocket costs for families.
-OCCYSHN participated in analyzing and tracking healthcare legislation proposed during the February, 2008 Oregon legislative session and to inform the development of educational print materials and presentations to families, providers, and partners.
-Delivery of health services to CYSHN via telemedicine was studied to determine its viability. OCCYSHN completed data collection and began analysis of cost and family and provider satisfaction of telemedicine genetics visits.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue Family Support Program to assist families with costs not reimbursed/paid by insurance or other funding		X		
2. Collect/analyze data related to out of pocket costs incurred by families				X
3. Educate/inform decision makers of the impact on families of out-of-pocket costs and needs for comprehensive coverage or additional funding for services, e.g. respite care				X
4. Provide information and education to families about maximizing healthcare and related benefits (CaCoon, CCN, partnerships with Family to Family Health Information & Education Ctr)		X		X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

-Provide testimony regarding impact and cost data for a bill mandating private insurance coverage of hearing aids for children.
-Join forums to identify, track and provide information on health care access and finance issues.
-Assess needs of selected communities; share findings on needs and facilitate discussion and planning to respond to identified CYSHN and local system of care issues.
-Provide financial assistance to families through FSP and gift funds.
-Continue collaboration with OHSC and DMAP to staff commission's genetic advisory committee to identify genetic services coverage issues and make recommendations about changes in coverage.
-Complete and disseminate cost and satisfaction data analysis for genetics telemedicine visits; monitor telemedicine reimbursement legislation.
-Survey MCO ENCCs regarding their need for information and TA on care coordination of CYSHN.
-Explore data sources for assessing the extent to which in-kind or charity care of CYSHN is delivered.
-Support efforts to identify financial resources for families to include in Disability Compass.
-Partner with the Oregon Insurance Division and Family Voices to train community partners about insurance issues, including benefits counseling.
-Partner with DMAP to identify issues related to care coordination and challenges of families in rural areas.
-Promote medical home including use of insurance benefits, availability of services for the uninsured, and sliding scale costs for health care through FQHCs.

c. Plan for the Coming Year

This measure was developed at a time when OCCYSHN received additional federal funding to allow it to address issues related adequate health insurance (NPM 4) in greater depth through the Strengthening Oregon's Communities integrated services grant. With the ending of those funds, OCCYSHN will plan and report its activities around adequate insurance under the rubric of national performance measure 4, and/or identify a new state performance measure at the end of its needs assessment activities.

State Performance Measure 10: *Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			80	80	82
Annual Indicator		80.3	80.3	72.4	80.3
Numerator		6988	6988	7200	6988
Denominator		8706	8706	9945	8706
Data Source					2005/06 NS-CSHCN
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	85	85	85	85

Notes - 2008

As in 2007, data reported for this State Performance Measure are from the 2005/2006 NS-CSHCN. These are the most current data available for measurement of progress toward this indicator. Please refer to "Notes - 2005" regarding the calculation of the numerator and denominator for this indicator.

Note on data: Of the estimated 8,706 families of CSHCN in Oregon living in rural areas, approximately 80 percent (6,988) indicated that their child had no unmet needs for services.

Data Source: Data used to compute this indicator from the 2005/06 NS-CSHCN. Of the estimated 8,706 respondents living in zip codes identified as non-Metropolitan Statistical Areas (MSAs), 80.3 percent indicated no unmet needs across a range of 15 different health, social and other services.

Notes - 2007
Source: National Survey of Children wtih Special Health Needs, 2005-06.

There are an estimated 116,988 CSHCN in Oregon. 8.5% of CSHCN population in Oregon live in small town/rural areas. 116,988 x .085 = 9945 CSHCN living in small town/rural areas of OR. 27.6% of CSHCN in OR had 1 or more unmet needs for health care services. (9945 x .276 = about 2745 CSHCN with unmet needs living in small town/rural areas of OR.) 9945 – 2745 = 7200 CSHCN with no unmet needs living in small town/rural areas of OR or 72.4%. This number is very similar to OCCYSHN reported in 2006 BUT it may not represent an improvement since there were more CSHCN living in small town/rural areas of OR (9945 vs. 8706) AND the level of unmet needs increased as well (27.6% vs. 19.7%). These shifts appear to result in a net increase in the number of CSHCN with unmet needs living in small town/rural areas of OR, but this may be in within the range of sampling error, something we will aim to examine this next program year.

Notes - 2006
2006 data is not available; 2005 data from the SLAITS NS-CSHN is carried forward.

a. Last Year's Accomplishments
-WSGSC telemedicine services continued in select rural areas. Staff worked to improve scheduling logistics to increase potential for telemedicine as an economic solution for access to genetics services. The program continued to collect cost and satisfaction data to be used to evaluate the viability of telemedicine as a method of offering genetics services and to inform decisions about using telemedicine for other specialty services.
-OCCYSHN partnered with LEND to provide community experiences for trainees, including Cornelius Latino community work, a community engagement topical seminar and a community-based training and in Tillamook where the Multi-modular three-day screening event screened 300 children in 12 health-related areas. A LEND faculty provided training to a CCN team and 26 community service providers on Cultural Responsiveness in Health Care. Of those who responded to a post-training evaluation, 100% indicated they were highly satisfied or satisfied.
-12 CDRC clinicians provided 4 consults and 18 in-service training to CCN teams and CaCoon Nurses to increase capacity in rural communities, including developmental pediatrician consults through a toll free line for community providers. OCCYSHN facilitated 9 other community-based consults and 4 additional consults with clinicians from outside CDRC.
-Screening Learning Collaborative continued in 5 communities with 3 additional learning sessions. Lessons learned were shared at OCCYSHN's statewide conference in April 2008. Participants indicated that the presentations and poster sessions provided by the SLC teams were effective in increasing their knowledge about screening practices at the community level.
-Partnered with the Oregon Department of Education and the Office of Family Health to focus on developmental screening and follow-up, improving Early Intervention processes through the ABCD Learning Academy.
-Family Liaisons in four rural counties worked to increase the number of local resources available on Disability Compass to assist families in their communities.

-Family Liaisons were added to CCN Teams bringing the total to 9 CCN sites and 2 rural practice sites, strengthening assurances that families are involved in the decision-making processes impacting their children.
-CaCoon continued to support PHNs in rural and frontier counties. Site visits were made to all counties in the state with TA available as needed and/or requested.
-Available ORCHIDS data was used to determine numbers served by CaCoon nurses.
-OFH and OCCYSHN consultants initiated quarterly meetings to collaborate on home visiting programs and to assure cross communication.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue and enhance OCCYSHN's community based activities, including CaCoon and CCN programs	X	X	X	X
2. Improve developmental screening policies, practices, and follow-up services (ABCD Learning Academy & OCCYSHN's Screening Learning Collaborative)				X
3. Provide focused training to providers throughout the state to increase capacity to provide care to CYSHN				X
4. Collaborate with CDRC providers to link services and information with providers in rural communities				X
5. Partner with other state agencies and organizations to advocate for policy changes that will benefit CYSHN and increase provider capacity to serve CYSHN				X
6. Pilot and promote alternative methods of training, information sharing, and service delivery (telemedicine)				X
7.				
8.				
9.				
10.				

b. Current Activities
-WSGSC analyzes cost and satisfaction data to evaluate the viability of telemedicine as a method of offering genetic and other specialty services.
-OCCYSHN utilizes community engagement and public health needs assessment methods to identify needs and improve services in rural communities.
-OCCYSHN trains local health departments on CYSHN-related topics.
-OCCYSHN partners with Disability Compass online database to promote use by families and providers, increase usage and expand resources.
-Partner with groups/agencies to educate policy makers about needs of families, including increasing access to medical homes and the need for comprehensive insurance coverage for CYSHN.
-Focus on developmental screening and access to follow up services through OCCYSHN's participation in the ABCD Learning Academy. Sustain effort through policy updates, information dissemination, and ongoing needs assessment activities with Screening Learning Collaborative teams.
-Collaborate with OFV, OFSN and the Oregon Family to Family Health Education and Information Center to increase family leadership and networking across the state.
-Partnering with OHSU psychiatrists and AMH, OCCYSHN continues efforts to enhance mental health services across the state through work with the Health Matters Subcommittee of the Early Childhood Services Committee.
-OCCYSHN explores alternatives to developing and sustaining connections with rural families and providers given increased travel costs and reductions in overall funding.

c. Plan for the Coming Year

This performance measure has been addressed predominantly through the efforts associated with OCCYSHN's last integrated services grant, "Strengthening Oregon's Communities." This 3 year grant, plus a one year extension, allowed OCCYSHN to increase the level of its outreach and impact on rural communities to a much greater extent. A learning collaborative on screening involving five rural communities was conducted; a focus on health care finance was initiated through this grant that concluded this year with the successful passage of the HB 2589, a hearing aid insurance mandate which requires commercial insurance regulated by the state to provide a $4000 benefit on a 4 year cycle. OCCYSHN provided technical assistance and education to interested groups addressing themselves to this bill, as well as testimony of the impact of this bill on children with hearing loss.

With the closure of this grant and the change in the program design, the activities that address rural communities will be substantially altered. They will include the following.

-CaCoon will periodically update and disseminate information on primary and specialty care through the state, especially rural areas, to assure knowledge of these services.

-The OCCYSHN Needs Assessment, in collaboration and coordination with the Office of Family Health, will identify numbers of CYSHN in rural and frontier counties and establish priority needs. Collaborate with OFH to maximize services for CYSHN including exploring opportunities to meet the needs of youth with special health needs through CCN partnerships with School Based Health Centers.

-Explore opportunities to engage/partner with rural health care collaborators through medical consultation as well as other linkages.

-Inform health care reform and health care delivery pilot projects including those in rural areas through dissemination of promising practices used in providing coordinated health care to CYSHN.

-CaCoon consultants will explore increasing care coordination to school age children if TCM services are expanded.

-OCCYSHN will explore the extent to which dental and mental health services are available to CYSHN and formulate an approach to address unmet needs.

-OCCYSHN will engage partners and community providers to explore access to health-related autism screening and treatment services throughout the state, including rural areas.

-Monitor legislative activity impacting CYSHN, including those in rural areas of the state.

E. Health Status Indicators

Introduction

Demographic information and data from vital statistics, including poverty levels, describe the Oregon population at large and reflects changes in the proportion of population subgroups. The information allows the Title V programs to identify those areas that need assessment or further analysis. Population changes drive the
ability of the Title V programs to serve a specific population with health disparities or inequities. In Oregon, the major population changes continue to be among the Hispanic population, including those who are citizens or are undocumented. The service requirements for this population group require specific cultural
competencies among providers and access to care not covered by Medicaid.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Indicator	6.1	6.1	6.1	6.1	6.0
Numerator	2764	2808	2971	3009	2899
Denominator	45660	45905	48676	49223	48190
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Oregon Center for Health Statistics, 2008.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

Narrative:
Oregon's rates for low and very low birthweight (#01a-02b) have changed very little since 2003, with no significant changes in the very low birthweight numbers for 2003-2008. Oregon's rates continue to be well below the 2006 national rate of 8.3% (National Vital Statistics Reports, Volume 57, Number 7, January 7,
2009).

Changes in the rate of infants born pre-term and/or with low or very low birthweight are factors in service delivery planning or coverage. Oregon has fewer health providers, especially OB/GYN practitioners, and most significantly, many practitioners do not accept clients covered by Medicaid. In addition, there are few
specialists for children with special health needs, except in the Portland metropolitan areas. An additional factor that contributes to timely delivery of services or referrals to specialists is complicated by reliable transportation, remote and rural communities, and weather conditions in those rural areas.

/2010/ The percent of births that are low birth weight (less than 2,500 grams) has remained steady. In 2008, it was 6.2% whereas it was 6.1% for each year in the 2004-2007 time period. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.4	4.7	4.7	4.7	4.5
Numerator	2017	2085	2198	2232	2115
Denominator	45660	44554	47176	47692	46712
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Oregon Center for Health Statistics, 2008; denominator excludes multiple births.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

Narrative:
In additional to information in HIS #1A above, changes are more apparent among singleton births than in the general population, these changes have led us to conclude that Oregon's overall increases in low birthweight are probably resulting from increased elective cesarean deliveries, especially for infants whose gestational age has been incorrectly inferred from ultrasound dating of the pregnancy.

/2010/ The percent of singleton births that are low birth weight (less than 2,500 grams) has remained steady. In 2008, it was 4.6%. For 2004-2007, it ranged from 4.4 to 4.7 percent. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.1	1.0	1.0	1.0	1.0
Numerator	498	477	508	479	487
Denominator	45660	45901	48676	49210	48190
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Oregon Center for Health Statistics, 2008.

Notes - 2007
Oregon Center for Health Statistics, 2007

Notes - 2006
2006 data will be available in late 2007.

Narrative:

/2010/ The percent of births that are very low birth weight (less than 1,500 grams) has remained steady. In 2008, it was 1.1%. For 2004-2007, it ranged form 1.0-1.1%. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.8	0.8	0.8	0.8	0.8
Numerator	371	353	366	361	365
Denominator	45660	44554	47176	47680	46712
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Oregon Center for Health Statistics, 2008; denominator excludes multiple births.

Notes - 2007
Source: Oregon Center for Health Statistics

Notes - 2006
Source: Oregon Center for Health Statistics

Narrative:
/2010/ The percent of singleton births that are very low birth weight (less than 1,500 grams) has been exactly 0.8% for each year from 2004-2008. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.2	6.1	8.5	8.5	8.5
Numerator	67	43	60	60	60
Denominator	729110	699202	702864	702864	702864
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data pulled from WISQARS on 4/30/09. More recent data is not available.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Notes - 2006
2006 data from CDC Web-based Injury Statistics Query and Reporting System.

Narrative:
Childhood injury rates have not changed significantly over the past few years. These data are used in Oregon to determine the effectiveness of current interventions and programs leveraged by Title V. Systems are in place to support education and awareness among parents, schools, health providers, and other service providers to prevent injuries including injuries sustained in motor vehicle crashes. A news release in April, 2008, reports that Oregon has reduced unintentional injury deaths to children by 54% since 1995, higher rate of decline than the 45% nationally. The leading injuries causing death during that time are motor vehicle deaths -- 44%; suffocation -- 18%; drowning -- 13%; fire -- 5%; and other land transport (primarily all-terrain vehicles) -- 4%. The reduction in deaths is credited to a multitude of efforts by individuals, community organizations, and governmental agencies.

/2010/ The death rate per 100,000 due to unintentional injuries among children 14 years and younger has shown no particular trend, decreasing from 9.2 to 6.1 from 2004 to 2005 and then increasing to 8.5 in 2006. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.6	3.0	3.3	3.3	3.3
Numerator	26	21	23	23	23
Denominator	729110	699202	702864	702864	702864
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data pulled from WISQARS on 4/29/09.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System.

Notes - 2006
2006 data from CDC Web-based Injury Statistics Query and Reporting System.

Narrative:
/2010/ The death rate in 2006 from unintentional injuries due to motor vehicle crashes among children 14 years and younger indicates a rate of 3.3 deaths per 100,000. This rate is comparable to the rates for 2004 (3.6) and 2005 (3.0). //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	25.3	23.7	23.8	23.8	23.8
Numerator	126	113	116	116	116
Denominator	498421	476089	487935	487935	487935
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Notes - 2007
2006 data from CDC Web-based Injury Statistics Query and Reporting System. More recent data is not available.

Notes - 2006
2006 data from CDC Web-based Injury Statistics Query and Reporting System.

Narrative:
/2010/ The most recent data for this measure (2006) indicates a rate of 23.8 deaths per 100,000 children aged 15 through 24 from unintentional injuries due to motor vehicle crashes. This rate is comparable to the rates for 2005 (23.7) and slightly less than the rate from 2004 (25.3). //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	183.9	230.3	174.0	174.0	174.0

Numerator	1341	1610	1222	1222	1222
Denominator	729110	699202	702322	702322	702322
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2007
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2006
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Narrative:
/2010/ The most recent data for this measure (2006) indicates a rate of 174 non-fatal injuries per 100,000 children aged 14 years and younger. This rate is substantially lower than the rate for 2005 (230.3) but comparable to the rate for 2004 (183.9). //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	30.7	24.5	20.2	20.2	20.2
Numerator	224	171	142	142	142
Denominator	729110	699202	702191	702191	702191
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: Hospital Discharge Data, 2006. Data for 2007-2008 not available.

Notes - 2007
Source: Hospital Discharge Data, 2006. Data for 2007-2008 not available.

Notes - 2006
Source: Hospital Discharge Data, 2006.

Narrative:
/2010/ The most recent data for this measure (2006) indicates a rate of 20.2 non-fatal motor vehicle injuries per 100,000 children aged 14 years and younger. This is a substantial decline from 2004 (30.7) and 2005 (24.5). //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	126.2	141.4	111.3	111.3	111.3
Numerator	629	673	550	550	550
Denominator	498421	476089	494160	494160	494160
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2007
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Notes - 2006
Source: 2006 data comes from 2008 Injury in Oregon Annual Report; no data for 2007-2008.

Narrative:
/2010/ The most recent data for this measure (2006) indicates a rate of 111.3 non-fatal motor vehicle injuries among children aged 15-24 years. This is substantially lower than both 2004 (126.2) and 2005 (141.4). //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	17.8	18.0	18.0	20.1	21.4
Numerator	2194	2202	2202	2516	2672
Denominator	123273	122333	122333	125165	125090
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 15-19 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2007
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 15-19 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2006
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 15-19 comes from Portland State Population Center Annual Population Report (2008), table 9.

Narrative:
Chlamydia rates among teen and adult women for the past several years are unchanged. These rates reflect the extent of safe sex practices and awareness among women and their partners of sexually transmitted diseases. Oregon has a system in place through a variety of programs to provide outreach to women who may be at risk, such as family planning clinics, universities and school-based health centers, social service programs, and community venues.

/2009/ The Public Health Division is working with the Oregon Public Health Lab to support a new kind of Chlamydia test that does not require a pelvic exam. The availability of Nucleic Acid Amplification Tests (NAAT urine tests) is expected to increase both primary screening and re-screening rates by eliminating the need for women to undergo a pelvic exam. The Dept. of Human Services is submitting a Legislative Concept to amend Oregon law to allow for the practice of Expedited Partner Therapy (EPT) for treating the sexually transmitted infections (STIs) Gonorrhea and Chlamydia in Oregon. Permitting EPT gives medical providers one more tool to effectively treat STIs and reduce re-infection rates by allowing them to prescribe or dispense antibiotic therapy for the sex partners of individuals infected with Chlamydia and Gonorrhea, even if they have not been able to perform an exam of the patient's partner(s). //2009//

/2010/ The rate of Chlamydia among women 15-19 steadily increased from 2004 to 2008. In 2004, the rate was 17.8 whereas in 2008 the rate was 21.4. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.2	5.9	6.3	7.0	7.4
Numerator	3261	3874	3874	4355	4665
Denominator	625262	656610	610656	622223	633145
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 20-44 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2007
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 20-44 comes from Portland State Population Center Annual Population Report (2008), table 9.

Notes - 2006
Source: Chlamydia cases from HIV / Sexually Transmitted Disease / Tuberculosis (HST) Program, Public Health Division. Number of women 20-44 comes from Portland State Population Center Annual Population Report (2008), table 9.

Narrative:
/2010/ The rate of Chlamydia among women 20-44 has steadily increased from 2004 to 2008. In 2004, the rate was 5.2 whereas in 2008 the rate was 7.4. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	48180	39514	1039	713	2128	335	1556	2895
Children 1 through 4	195293	168137	5968	4217	7515	695	8761	0
Children 5 through 9	234635	202058	6835	4414	8867	888	11573	0
Children 10 through 14	237396	206578	6629	3822	8791	804	10772	0
Children 15 through 19	247556	217893	6420	4559	8228	889	9567	0
Children 20 through 24	242667	214663	5825	4512	8696	951	8020	0
Children 0 through 24	1205727	1048843	32716	22237	44225	4562	50249	2895

Notes - 2010
Oregon Center for Health Statistics, 2008; infants are based on race of mother.

Narrative:
The total estimated population of infants and children aged 0 through 24 years in Oregon during 2007 was 1,243, 342. Within this population, 90.4 percent were White, 3.2 percent were Black,

2.0% were American Indian/Native Alaskan and 4.3 percent were Asian. For ethnicity, 15.3% percent were Hispanic/Latino and 84.7% percent were non-Hispanic/Latino.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	38020	10094	76
Children 1 through 4	150235	45058	0
Children 5 through 9	186883	47752	0
Children 10 through 14	197098	40298	0
Children 15 through 19	213790	33766	0
Children 20 through 24	211964	30703	0
Children 0 through 24	997990	207671	76

Notes - 2010
Oregon Center for Health Statistics, 2008; infants are based on race of mother.

Narrative:
Interpretation integrated in HSI #6A

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	38	21	4	0	1	0	3	9
Women 15 through 17	1314	977	49	50	11	4	84	139
Women 18 through 19	3063	2443	95	92	26	16	145	246
Women 20 through 34	37046	30657	773	502	1521	279	1196	2118
Women 35 or older	6726	5414	118	69	569	36	138	382
Women of all ages	48187	39512	1039	713	2128	335	1566	2894

Notes - 2010

Narrative:
The overall racial makeup in Oregon shows little evidence of change. For example, as noted above, 90.4% of children 0-24 are White. Similarly 89.3% of births in 2007 were to White

mothers. On the other hand, there is a trend towards an increasing percent of Hispanic children. Whereas Hispanics comprise 15.3% of all children 0-24, they comprise 20.4% of infants 0-1.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	17	21	0
Women 15 through 17	743	569	2
Women 18 through 19	2140	915	8
Women 20 through 34	29513	7473	60
Women 35 or older	5605	1115	6
Women of all ages	38018	10093	76

Notes - 2010

Narrative:
Interpretation integrated in HSI # 7A

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	237	179	17	10	6	6	3	16
Children 1 through 4	46	36	2	2	1	1	1	3
Children 5 through 9	32	29	1	0	0	0	0	2
Children 10 through 14	27	21	1	0	1	0	0	4
Children 15 through 19	120	100	3	3	2	2	6	4
Children 20 through 24	180	152	7	8	1	0	3	9
Children 0 through 24	642	517	31	23	11	9	13	38

Notes - 2010

Narrative:
In 2008, white children accounted for 80.5% of deaths to children age, Blacks 4.8%, American Indians 3.6%, Asians, 1.7% and Hawaiian/Pacific Islanders 1.4%. Those with more than one

race accounted for 2.0% of deaths and others/unknown for 5.9%. Comparisons to the overall racial composition of 0-24 year olds is not possible because the most recent population data only includes the Hawaiian/Pacific Islander, more than one race, and other/unknown categories for 0-1 year olds whereas the death data includes those categories for the full 0-24 age group.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	176	60	1
Children 1 through 4	36	10	0
Children 5 through 9	26	6	0
Children 10 through 14	19	8	0
Children 15 through 19	109	11	0
Children 20 through 24	157	23	0
Children 0 through 24	523	118	1

Notes - 2010

Narrative:

Interpretation integrated in HSI #8A

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	952648	836221	27390	18217	35630	2804	32054	332	2007
Percent in household headed by single parent	19.0	17.6	31.6	0.0	0.0	0.0	28.1	20.5	2004
Percent in TANF (Grant) families	6.7	4.4	22.6	9.2	2.1	0.0	0.0	0.0	2007
Number enrolled in Medicaid	273378	144836	12671	5765	6755	0	0	103351	2008

Number enrolled in SCHIP	273378	144836	12671	5765	6755	0	0	103351	2008
Number living in foster home care	13965	9290	1033	1479	129	59	0	1975	2008
Number enrolled in food stamp program	210986	180811	15414	6363	5115	1335	30	1918	2008
Number enrolled in WIC	102648	50565	2776	1656	2544	0	2750	42357	2007
Rate (per 100,000) of juvenile crime arrests	3188.9	2830.3	7890.1	2273.9	776.5	0.0	0.0	0.0	2005
Percentage of high school drop-outs (grade 9 through 12)	3.7	3.0	7.0	5.8	2.6	0.0	0.0	0.0	2008

Notes - 2010
Population by Age and Sex for Oregon and Its counties (Table 9), July 1, 2007. Prepared by Population Research Center, Portland State University.

Division of Medical Assistance Programs.
http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtm.

Source: DHS Child Welfare Research and Reporting Unit. Unduplicated clients, end of month master files, age 0-19 at time of pull, 5/23/09; 2008 data not available.

Source: Division of Medical Assistance Programs, HCFA-416 Report. Data for Medicaid and SCHIP is not available separately.

Source: Division of Medical Assistance Programs, HCFA-416 Report. Data for Medicaid and SCHIP is not available separately.

Source: DHS Child Welfare Research and Reporting Unit. Unduplicated clients, end of month master files, age 0-19 at time of pull, 5/23/09; 2008 data not available.

Source: 2007 Pediatric Nutrition Surveillance System, CDC, Table 1-C.

Source: Oregon Criminal Justice Information Systems. More recent data by race and ethnicity not available. http://www.oregon.gov/OSP/CJIS/annual_reports.shtml

Source: Oregon Dept. of Education, Early Learners Dta Collection, Table A-2. 2007-2008.

Source: Dept. of Human Services, Children Adult and Families Division, received from Judy Satrum, 6/3/09.

Narrative:
Items of note from the miscellaneous demographic data include the following:

• In 2004 (the most recent year for which data is available), Blacks (31.6%) were much more

likely to be living in a household headed by a single parent than whites (17.6%).
• Similarly, in 2007, Blacks were much more likely to receive TANF (22.6%) than other racial/ethnic groups (second highest was Hispanic at 10.8%). While Blacks were also a disproportionate percent of the Food Stamp population, their percent of the caseload (7.3%) was much smaller.
• Children who were American Indian/Alaskan Native (10.6%) or Black (7.4%) were more likely to be living in foster care than their overall percent of the child population (2.0% and 3.2% respectively).
• The juvenile crime rate among Blacks was substantially higher than that of other racial/ethnic groups. The rate among Asians was substantially lower than the state average.
• Several groups (Blacks, American Indian/Alaskan Natives and Hispanics) had dropout rates that were substantially higher than the state average.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	719427	146446	0	2007
Percent in household headed by single parent	20.0	18.9	0.0	2004
Percent in TANF (Grant) families	3.1	10.8	0.0	2007
Number enrolled in Medicaid	170027	84212	19139	2008
Number enrolled in SCHIP	170027	84212	19139	2008
Number living in foster home care	11811	1387	767	2007
Number enrolled in food stamp program	32368	24115	0	2007
Number enrolled in WIC	60291	42357	0	2007
Rate (per 100,000) of juvenile crime arrests	3443.3	1843.1	0.0	2006
Percentage of high school drop-outs (grade 9 through 12)	3.2	6.4	0.0	2008

Notes - 2010
Population by Age and Sex for Oregon and Its counties (Table 9), July 1, 2007. Prepared by Population Research Center, Portland State University.

Division of Medical Assistance Programs.
http://www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtm.

Source: DHS Child Welfare Research and Reporting Unit. Unduplicated clients, end of month master files, age 0-19 at time of pull, 5/23/09; 2008 data not available.

Source: Division of Medical Assistance Programs. Data for Medicaid and SCHIP is not available separately.

Source: Division of Medical Assistance Programs. Data for Medicaid and SCHIP is not available separately.

Source: DHS Child Welfare Research and Reporting Unit. Unduplicated clients, end of month master files, age 0-19 at time of pull, 5/23/09; 2008 data not available.

Source: Oregon Criminal Justice Information Systems. More recent data by race and ethnicity not available. http://www.oregon.gov/OSP/CJIS/annual_reports.shtml

Source: Oregon Dept. of Education, Early Learners Dta Collection, Table A-2. 2007-2008.

Source: Dept. of Human Services, Children Adult and Families Division, received from Judy Satrum, 6/3/09.

Narrative:

Interpretation integrated in HSI #09B

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	869351
Living in urban areas	696258
Living in rural areas	245049
Living in frontier areas	10673
Total - all children 0 through 19	951980

Notes - 2010

Narrative:
The vast majority of children in Oregon (91.3%) live in metropolitan areas. The rest (8.7%) live in non-metro areas. Most Oregon children (73.1%) live in urban areas, with the rest living in rural (25.7%) or frontier (1.1%) areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	3745455.0
Percent Below: 50% of poverty	0.6
100% of poverty	11.8
200% of poverty	30.6

Notes - 2010

Narrative:
A very small percentage of the overall Oregon population is below 50% of poverty (0.6%). However, for children, this percentage is much higher (7.0%). Similarly, children are more likely to be below 100% and below 200% of poverty than the general population.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	951969.0
Percent Below: 50% of poverty	7.0
100% of poverty	16.7
200% of poverty	37.9

Notes - 2010

Narrative:
Interpretation integrated in HSI #11

F. Other Program Activities

- MCH Toll-free Telephone Number: SafeNet was established in April 1991, and is funded jointly by the Title V and Title XIX Agencies. The service is provided through an interagency agreement with 211Info and the Office of Family Health. SafeNet, is designed to link low income Oregon residents with health care services in their communities; assist in identifying and prioritizing needs of callers with immediate, multiple health care concerns; match provider callers with appropriate information concerning options; track and document service gaps; and provide follow-up and advocacy to insure that clients statewide are able to access available services. Outreach for SafeNet occurs through Medicaid card messages and inserts (WIC, prenatal, flu, and dental), televised PSA's (both national and local), websites, DHS offices, OHP staff, local health departments, private providers, managed care plans and social service agencies. Special advertising campaigns designed to move particular target audiences to call SafeNet for particular time-sensitive information is conducted periodically. SafeNet is utilized as a part of other nutrition and food assistance programs such as in Food Stamp Outreach and Summer Food site information. At present eleven staff members are fully trained in taking Oregon SafeNet calls. /2007/ Women's health resources are now included in the SafeNet database. SafeNet worked with an OFH data analyst to create a system to identify service gaps for women in the state by examining "unmet need" calls. //2007//

/2008/ SafeNet and OFH recognized that the number of Spanish speaking callers did not come close to representing the Spanish speaking population in Oregon. SafeNet collaborated with Migrant Head Start staff to conduct interviews and focus groups to define the problem. The result is a very successful design for an outreach campaign to promote SafeNet to low income Spanish speaking families in Oregon. //2008//

- A Prenatal and Newborn Resource Guide for Oregon Families is the third version over the years. The booklet has content in Spanish on the left page and English content on the right page. The book was originally designed and disseminated to hospitals and birthing centers to distribute to new mothers, and included content specific to health and care of newborns and early childhood. The current version adds prenatal content and is distributed to providers of prenatal care services instead of hospitals and birthing centers. The guide is available on http://www.oregon.gov/DHS/ph/ch/newborn_resource_guide.shtml

- The Immunization Program received a grant to study the immunization practices and beliefs of those parents who claim religious exemptions to school immunization requirements and a CDC Registry Sentinel Site Capacity Building Grant to improve immunization registry data quality and to provide support for routine analysis of immunization registry data. /2007/ The Immunization Program is shifting to CDC's vaccine distribution process to reduce the number of times vaccines change hands. Local health departments will receive vaccines directly from distributors, rather than through the state Immunization Program. Oregon and Washington immunization registries completed a Data Exchange to provide more complete shot histories for both states and avoid the cost of duplicating a child's shots. //2007//

/2008/ The Immunization Program is expanding access to free vaccines for underinsured children through the Vaccines for Children (VFC), in collaboration with county health departments and FQHCs. A study in early 2008 for a registry-based Reminder/Recall study will guide planning for expanding the ages and types of contacts made with parents to encourage timely immunizations. New school immunization requirements for hepatitis A, 2nd dose, Varicella, and pertussis will take effect in school year 2008-09. //2008//

The Oregon WIC Program was awarded a 3 year research grant to implement and evaluate the impact of peer counseling on breastfeeding duration among Oregon WIC clients. This study will use sound scientific methodology to answer important questions about effectiveness of peer counseling and support. /2007/ WIC entered its second year of a 3-year USDA funded study Breastfeeding Peer Counseling. This randomized control trial underway at three local WIC agencies seeks to determine the effect of telephone based peer support on the breastfeeding duration of Oregon WIC clients. //2007//
/2008/ WIC entered its third and a final year of a randomized control trial to determine whether telephone based peer counseling can increase breastfeeding duration and exclusivity among WIC clients in three study sites. Close to 2,000 women have been enrolled in the study, and preliminary results should become available before the end of the year. //2008//

- The Oregon WIC Program was also awarded a one year research grant to do an initial investigation of the development of a series of health messages to encourage fruit and vegetable consumption among families with young children. This study will address the questions around the best ways, messages, and message delivery to encourage low income families to eat more fruits and vegetables. /2007/ In September 2005, WIC was awarded funding by USDA to conduct a three-year research study titled "Using Motivational Interviewing and Boosters to Increase the Offering of Fruits and Vegetables by WIC Parents of Preschoolers." The goal is to integrate these practices into WIC nutrition education programming. The first local agency piece is beginning in late summer of 2006. //2007//
/2008/ The three local agencies participating in this study received initial training in motivational interviewing, followed by monthly continuing education pieces created by state staff. Although study results will not be available until 2008, early feedback from local agency staff show the technique to be highly popular and is perceived by local staff as being a more effective way of counseling clients. //2008//

/2009/ The Womens' and Reproductive Health Section was awarded a 5 year grant from the Centers for Disease Control and Prevention (CDC) to implement a WISEWOMAN program here in Oregon to decrease the risk of heart disease and strokes among low-income women by promoting early detection and prevention. The work under this grant will provide cardiovascular risk factor screening, risk reduction, and access to treatment to low-income, uninsured/under insured women 40 - 64 years of age currently receiving services through the Oregon Breast and Cervical Cancer Program. //2009//

/2009/ OCCYSHN's CaCoon program has begun to establish an active relationship with the Exceptional Needs Care Coordinators on behalf of Title V CSHCN's population. ENCCs were invited and attended the annual OCCYSHN conference in which they were introduced to the

CaCoon program and its support materials around care coordination for CYSHN and their families. This effort will be continued as a partnership in assuring effective care coordination for this population. //2009//

/2010/ The Health Care Coalition of Southern Oregon has been awarded a 5 year 3 ¼ million dollar grant award by the federal Healthy Start (DHHS/HRSA) program to continue with this work through the health departments and safety net clinics. The pregnant women will receive health education, home visits, screening for depression and other services to help improve their health and the health of their babies. //2010//

G. Technical Assistance

Oregon's Title V technical assistance requests are to support agency and program efforts to address 2010 and ongoing needs assessment, strategic planning, and workforce development and competencies.

2010 Needs Assessment Support
MCH Priorities Advisory Group
The Oregon Title V Needs Assessment is focusing on establishing priorities by eliciting the opinions, ideas and experiences from stakeholders and diverse community representatives. The plan is to hold two-three large meetings that will accomplish the goal to inform and listen to participants in the advisory group, which will direct the priorities for the next five years of Title V work.
Purpose: Facilitate statewide advisory group meetings, leading to priority setting for Title V Block Grant performance measures and activities
Supports: Data related issues - Five-Year Needs Assessment
Proposed Consultant: Group Facilitator with experience in leading diverse group processes, goal setting and planning

Statewide Planning
Child Health Summit
State and Local MCH Public Health Nursing leadership was successful in 2007-2008 in jointly identifying statewide priorities for perinatal health. The outcomes led to action plans and shared activities around maternal depression and preconception health. The MCH state-local leaders would like to conduct a similar retreat to determine two priorities for children's health for ages 3 to 10 years. The desired outcome is to identify leading priorities, develop action plans, and jointly work on addressing the priority issues through state and local public health activities.
Purpose: Facilitate priority setting and planning for child health priorities
Supports: General Systems Capacity: Title V needs assessment and priority setting
Proposed Consultant: Facilitator with expertise in MCH Public Health and Public Health Nursing for a two-day retreat

Autism Summit
Oregon continues to show high rates of autism in children and families, providers, educators and policy makers are struggling with increasing unmet needs of children and youth with autism. Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) is planning a statewide summit with broad-participation to conduct a needs assessment, identify priorities and plan activities to as part of its needs assessment and in anticipation of future funding. Desired outcomes are a list of family and professional partners committed to action in working on policies and funding as well as clearly delineated priorities for activities and training needs.

Purpose: Assistance in developing an agenda and strategies for funding and bringing together individuals and groups with widely varying agendas to commit to an action plan to be facilitated through OCCYSHN.
Supports: General Systems Capacity
Performance Measure:
Proposed Consultants: Group Facilitator with experience in special health needs issues and leading diverse group processes, goal setting and planning

Young Adult Uninsurance
Even with expansion of the Oregon Health Plan, a significant gap of young adults, ages 19-24, who are uninsured will likely continue, especially as employment rates among this population continue to be high. The OFH Adolescent Health Section will be working on policy potential legislation for 2011. Research will be conducted during 2009 to analyze the scope of the issue and problems, and a potential stakeholder meeting will be set during 2010. The purpose would be to bring in an expert from another state to learn about policy and legislative strategies to increase insurance rates among this population.
Purpose: To develop policy proposals for providing health insurance for young adults
Supports: General Systems Capacity
Proposed Consultants: National or local consultant familiar with strategies implemented in other states around young adult health insurance

Capacity Building
Action Plan for Ongoing Assessment Capacity
The Oregon Title V Program created a new unit as part of the plan to build capacity identified in the last needs assessment. The MCH Assessment and Evaluation Unit has been fully staffed since Fall 2008, and is continuing to build organizational structure and capacity to activities, such as focus groups, topic work groups, data analysis, and planning. The next phase in developing capacity to create an organization development plan and workforce with appropriate competencies for ongoing assessment and evaluation that supports Title V priorities.
Purpose: Organizational action plan to build assessment competencies
Supports: Data Related Issues: Title V Needs Assessment and Monitoring
Proposed Consultants: Organizational development facilitator

OCCYSHN Comprehensive Evaluation and Assessment Plan
A comprehensive and manageable ongoing plan of program evaluation and assessment is needed to inform and guide OCCYSHN's limited evaluation resources. Increasingly, data about status and services for children with special health needs is needed to adequately and expertly inform public and organizational development of policies, programs and decisions. OCCYSHN needs assistance to plan and create an organizational strategy that will improve capacity for evaluating outcomes of our systems of care efforts at the community-based level, and strategies for funding these activities in an intense budget limiting environment.
Purpose: Increase capacity of OCCYSHN evaluation and assessment capacity
Supports: Data Related Issues: Data systems and needs assessment
Proposed Consultant: Champions Technical Assistance Center and Holly Grayson of University of Washington

Asset Mapping and Dissemination of Financial Resources and Insurance Supports for Families
With current economic conditions and significant un/under-insurance issues for families of children with special needs, OCCYSHN would like to take a lead role in 1) obtaining data of recession impacts on families of children with special health needs, and 2) identifying and disseminating resources available to families and providers to assist in meeting coverage and financing needs. Community asset mapping is a strategy to identify needs and resources for families. OCCYSHN would

like technical assistance from the Catalyst Center create strategies and activities that will address family financial hardships.
Purpose: A strategic plan for reducing impact of family financial hardships
Supports: Performance Measures: Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need; and State Performance Measure 10: Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.
Proposed Consultants: Catalyst Center

Workforce Development
Medical Home Training for Physicians and Community Providers
Current efforts around health care reform in Oregon emphasize the need for coordinated primary care but often do not include the comprehensive practice of medical home for children and youth with special needs as identified by MCH, AAP, and others. OCCYSHN believes there is a need to provide consultation and training around Medical Home for physicians and other community providers who provide primary care to CYSHN. Although information is available online, personalized training in Oregon is expected to result in broader implementation of the national model for CYSHN.
Purpose: Training for primary care providers that includes principles and strategies for improving the practice of Medical Home.
Supports: Performance Measures: Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home; State Performance Measure 8: Percent of health care providers who report confidence in caring for CYSHN and their families
Proposed Consultants: Dr. Fan Tait, Associate Executive Director of the American Academy of Pediatrics (AAP) and Director of the Department of Community and Specialty Pediatrics at the AAP.

Intimate Partner Violence/Child Abuse Training
Public Health Nurses (PHN) who conduct home visiting with at-risk families often encounter a variety of home life situations that can have an emotional impact on the Nurse. While professional, some PHNs may be inexperienced in how to handle the emotional impact they experience and/or provide appropriate plans of actions for clients, especially for those living in rural communities.
Purpose: Training for county PHNs is needed to help them deal with IPV, CA and strategies for helping clients get the services they need, especially small and rural communities.
Supports: General system capacity issue
Proposed Consultants: Expert in risk communication for health professionals or related field

Population Status Evaluation
Elementary School Self-Report Surveys
A 4-6 grade survey has been piloted, developed using two other state surveys. The next step is to develop the survey for on-line completion and need outside expertise to review the survey and develop recommendations for the survey content and analysis. The survey results would used at the school or district level to evaluate trends and planning around health issues, focused on topic areas such as physical activity, nutrition and safety.
Purpose: To create an on-line survey appropriate for 4-6 grade youth
Supports: Data related issues
Proposed consultants: Consultant with expertise in developing survey questions and content appropriate for children

V. Budget Narrative

A. Expenditures

The expenditures for the Federal/State Partnership include all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The match also includes expenditures in local health departments not reimbursed by federal funds, including those matching funds received by the county for Targeted Case Management and Medicaid Administrative Match. The State MCH Funds are a combination of state general funds, other non-federal grant funds to the state, and county expenditure and revenue reports submitted to the Public Health Division for Perinatal, Babies First, and School Based Health Centers programs. County reports do not separate these revenue sources when reporting expenditures, therefore the revenue reports are used in both budget and expenditures as part of the MCH state match.

The expenditures and the budget for the Federal/State Partnership are prorated among populations:
- Pregnant Women: Perinatal Program (Block Grant and General Funds)
- Children <1 year: Babies First! Clients < 1 year (General Funds); Public Health Lab Newborn Screening (Other Funds - Fees)
- Children 1-22 years: Babies First! Clients > 1 year (General Funds); Child and Adolescent Health, Injury Prevention, Oral Health, Teen Pregnancy Prevention (Block Grant funds); School Based Health Centers (General Funds); Immunization (Block Grant portion); Family Planning (Block Grant funds)
- CSHCN: CaCoon, Community Connections (Block Grant, Clinical Fees, General fund match)

Title V match requirement is calculated from state general funds and other non-federal funds in the Office of Family Health and OCCYSHN, that are not used for match for other federal programs. Other match is calculated from county MCH program expenditures using revenue sources that are non-federal (client fees, county general fund) and that is not used for federal match nor received from Medicaid Administrative Match.

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies count as Direct and Enabling Services. Funds that are used at the State level, in the Office of Family Health, are distributed between Population-Based and Infrastructure, prorated according the type of activities occurring in the state-level programs. OCCYSHN programs are allocated approximately 10-15% in Enabling services and the remainder in Infrastructure services.

The Oregon Title V Expenditures are generally based on reports from the Office of Family Health, Oregon Center for Children and Youth with Special Health Needs, and from county health department reports submitted to the Public Health Division. In each annual report, the expenditures are based on actual expenditures at the time of the preparation of the Title V report (around May of each year). This report should be considered preliminary since the expenditures for the most recent Federal Fiscal Year were not closed at the time of reporting. The expenditures for FY 2004 are based on expenditures to date (May, 2005) for the period October 1, 2003 to September 30, 2004. /2007/ Expenditures for FY 2005 are for the period October 1, 2004 through September 30, 2005. /2008/ Expenditures for FY 2006 are for the period October 1, 2005 through September 30, 2006. //2008// /2009/ Expenditures for FY 2007 are for the period October 1, 2006 through

September 30, 2007. //2009//
/2010/ The Expenditures for FY 2008 are for the period October 1, 2007 through September 30, 2008. //2010//

B. Budget

The Federal/State Partnership budget includes all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The budget does not include anticipated expenditures in local health departments using revenue from matching funds received by the county for Targeted Case Management and Medicaid Administrative Match.

The expenditures and the budget for the Federal/State Partnership are prorated among populations:
- Pregnant Women: Perinatal Program (Block Grant and General Funds)
- Children <1 year: Babies First! Clients < 1 year (General Funds); Public Health Lab Newborn Screening (Other Funds - Fees)
- Children 1-22 years: Babies First! Clients > 1 year (General Funds); Child and Adolescent Health, Injury Prevention, Oral Health, Teen Pregnancy Prevention (all Block Grant funds); School Based Health Centers (General Funds); Immunization (Block Grant portion);
- CSHCN: CaCoon, Community Connections (Title V Block Grant, Clinical Fees, mandated state general fund match)

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies count as Direct and Enabling Services. Funds that are used at the State level, in the Office of Family Health, are distributed between Population-Based and Infrastructure, prorated according the type of activities occurring in the state-level programs. OCCYSHN programs are allocated approximately 10-15% in Enabling services and the remainder in Infrastructure services.

The Office of Family Health, Title V Program, meets its 30-30 minimum requirement by transferring 30% of the Oregon MCH Block Grant appropriation to the OCYSHN for serving the children with special health care needs. No administrative or indirect is retained prior to transfer. The required Maintenance of Effort for Oregon is $3,950,427 and the DHS, Office of Family Health assures this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The state meets the required three-for-four dollar match. Source of funds for match are state general funds and county local funds, including patient fees, local general funds, and non-Medicaid 3rd-party payments, and are not used for match for other federal programs. The Oregon Legislature appropriates the state funds on a biennial basis and the state appropriates funds for local grants on an annual basis.

The proposed MCH budget is estimated using the Legislative Approved Budget for the 2003-05 biennium for the Office of Family Health. At the time of preparation, the 2005-07 Governor's Recommended Budget was not approved by the Legislature. The budgeted amounts are calculated to be half of the legislative approved spending limitation. /2007/ The FY 2007 budget is based on the LAB for the 2005-07 Biennium. //2007//
/2008/ The Budget for FY 2008 is based on the Governor's Recommended for state biennium

2007-2009. The Legislative Approved Budget, approved June 29, 2007, does not differentiate substantially from the Governor's recommended. //2008// /2009/ The budget for FY 2009 reported in Forms 2-5 are based on 50% of the Legislative Approved Biennial Budget adopted in July 2008. The level of the Block Grant is based in the current FY 2008 award as the FY 2009 budget for Title V is not approved at the time of this writing. //2009///

/2010/ The budget for FY 2010 in Forms 205 are based on one year of the Legislative Approved Biennial Budget for 2007-2009. At the time of submission for FY 2010 Block Grant Application, the approved budget for 2009-2011 was not yet complete. Known new grants are included in the other federal funds categories in the budget. //2010//

/2007/ The Title V Program in the Office of Family Health has not yet determined extent of cuts to the Block Grant in FY 2006. Oregon will be analyzing state level programs and activities early next federal fiscal year. Because of concurrent cuts in the state general fund and the phasing out of other grants, funds from other sources will not be available to backfill losses in Title V. //2007//

/2008/ OFH has managed Block Grant reductions through cost savings across the office, which include those savings resulting from staff vacancies and delays in purchasing supplies and equipment. OFH has also targeted other state level funding sources to backfill Block Grant reductions. For FY 2008, OFH will continue to shift costs where possible, but retains the strategy to not reduce contracted levels with county health departments. //2008//

/2009/ The OFH Budget was increased by the Legislature for the 2007-09 biennium, with an increase to expand School-Based Health Centers to $5.6 million a year. The CDC Physical Activity and Nutrition grant was not renewed for the Public Health Division, accounting for about $150,000 per year support in the Office of Family Health for child and adolescent nutrition activities and for breastfeeding promotion activities. Title V is backfilling these activities for now. The CDC Coordinated School Health grant was not renewed for Oregon creating a shortfall for the Healthy Kids Learn Better program. This program is being supported with Tobacco Prevention funds and state General Funds. On the other hand, new funds have been received for chronic disease management in a CDC Wisewoman grant. Pending grants are the CDC Genomics grant, CDC Oral Health Grant, HRSA First Time Mothers grant, and the ACYF Evidence-Based Home Visitation Grant. //2009//

/2009/ Affecting 2009 and the future are the cuts to county health department revenues due to the lack of federal renewal of timber tax revenue payments. This revenue will drastically reduce about a third of Oregon's counties' revenues that support public health, thus reducing their expenditures and ability to provide a share of the financial match for Title V, but also for other federal grants and Medicaid Administrative Match dollars. The actual impact is unknown at this time, and federal legislation is pending to cover one-more-year of the revenue, though it was not passed in time to meet the July 1, 2008 budget deadline for most county budgets. The timber tax revenue payments were established in the 1990's to help counties where the timber industry was severely cut. These counties subsequently utilized these federal revenues for local services rather than levy local taxes. //2009//

/2007/ For OCCYSHN, reduction in Title V block grant funds to Oregon resulted in a decrease in the CDRC outpatient clinic support. The 2004-05 quality

improvement exercise will be a starting point to evaluate how clinic dollars are spent by disciplines providing clinic services that are not reimbursed. It is anticipated that the revenue generated from an increase clinical services and better provider documentation will increase reimbursement and benefits counseling/advocacy will offset the reduction.

The annual Family Support Program funds were decreased. This program has been in operation for three years, and was under spent in the past. However, with the increase in the uninsured and increase in out-of-pocket expenses by families, combined with more word of mouth advertising of Family Support Program (FSP), it is anticipated that the funds will be fully utilized this year. Improved data collection and analysis is being pursued this year to provide a better understanding of expenditures from FSP funds. Reports and comments from families who have received these limited support dollars are very positive and indicate that services and products result in improved for quality of life.

Both the CaCoon program and Community Connections Network will be funded with a small cost-of-living increase. These two programs have been flat funded for the past two years despite increase in caseloads and services delivered. The formula used to determine the CaCoon Care Coordinator funding for each county will be reassessed and updated to reflect current population shifts and demographics including poverty and anticipated number of children with special health needs. The planned expansion of the Promatora program to additional counties (currently there are 4 counties that participate in this program) has been delayed to provide evaluation of funds available.

The OCCYSHN strategic plan will evaluate training needs over the next five years that will optimize skill building in a cost efficient manner. Face-to-face meetings are preferred by most partners, but travel expenses and time away from work site have created challenges in scheduling meetings. OCCYSHN will explore other options and evaluate the best venue for the proposed material/training. A partnership with Office of Family Health, Oregon Department of Education, Oregon Mental Health and Addictive Services and Oregon Family Voices will be able to reduce overhead cost of meetings. In previous years, Community Connections Network teams have been offered two Continuing Medical Education events per community per year. However, with the reduction in the Block Grant funds, combined with an increase cost of CME credits, each community will be offered only one program of their choice, with a certificate of attendance offered rather than CME credits. OCCYSHN staff will partner with hospital and Medical groups to offer CME for physicians to encourage engagement in the training opportunities offered through the Center. Additional training opportunities may be available to CCN teams through the integrated services grant, SOCs. //2007//

/2008/ Financial support to the CDRC clinics will remain the same with no further reduction. Both the CaCoon and Community Connections Clinics will be funded without a cost of living increase due to budget constraints.
//2008//

/2009/
The 1.7% reduction in MCH funding to the Title V Block Grant along with the corresponding state match, resulted in an overall reduction in OCCYSHN's budget for FY09 of $64,250. As a result of these reductions, further reductions were made to the financial support to the CDRC Clinics. CaCoon, Community Connections Network Teams and the Family Support Program dollars will remain constant. To the extent it is considered effective and feasible given the many rural areas into which OCCYSHN seeks to take its training programs, distance learning methods will be

employed to the fullest extent possible. Community Connections Network teams will be offered one educational or consultation program of their choice, and one staffed by an OHSU- CDRC clinician. This will be the first year in nearly 10 years in which the OCCYSHN will not have additional MCH dollars from integrated services grants or other sources of funding which have supported targeted curriculum and training development activities with which to extend its activities beyond a small no-cost extension to complete activities during FY09. The timber revenue cuts will significantly impact communities in their abilities to sustain their activities on behalf of CYSHN. Airline travel to rural communities will be eliminated or reduced significantly to make on-site work more difficult to achieve within budget realities. The ongoing in-kind support provided by community partners becomes ever more significant in OCCYSHN's ability to affect services through collaborative efforts at the community level. OCCYSHN will continue to apply for supplementary funding to supplement its activities. OCCYSHN will look toward continued partnerships, such as with Family Voices centered on family trainings, to continue its efforts.
//2009//

/2010/ CDRC and OCCYSHN is facing significant reductions in its state general fund and will be redesigning its structure to continue serving the Title V CYSHN populations. The Child Development and Rehabilitation Center clinic programs and the OCCYSHN will develop a partnership that will essentially reassign Title V funds. A new program will be developed and implemented with the goal to integrate CDRC's clinical activities with public health activities that benefit children with disabilities and complex conditions throughout Oregon. Outcomes for this refined effort are expected to improve efficiencies in policy, systems of care, provider and parent preparation in the care of CYSHN. Areas of the new integrated clinical and public health program include emphasis on care coordination, behavioral health, medical consultation in developmental pediatrics with specialty emphasis on autism, genetics and high risk infant care and follow-up. This effort is being designed to benefit children at the local level and through systems change at the state level. Activities that are clinic and/or center based will be leveraged to provide community-based outreach clinics to better meet the needs of CYSHN at the local level. Principles and practices of family professional partnerships and family-centered, cultural competent, high quality services will be emphasized on a continuous basis. There will be a continuous effort to link CDRC specialty care and expertise with community providers and families with local as well as state resources to better meet their needs.

These changes will have ramifications to longstanding OCCYSHN programs. CaCoon will experience a 10% reduction in funding to the communities; Community Connections Network Teams will be reduced to accommodate a 36% reduction in that program's budget. The Family Support Program is currently closed for re-evaluation and redesign to accommodate significantly reduced amount of funds available for distribution. New administrative procedures will have to be identified to make it a viable program for implementation. These services have provided support to 716 children. State reductions require a re-evaluation of the delivery method as these support dollars have been reduced from this past program year.

Community Connections Network (CCN), operating in fourteen primarily rural communities to promote inter- and multi- disciplinary care and coordination, will experience an overall reduction of support of 36%. This will require a reduction to nine teams. OCCYSHN and the CCN provides minimal financial support and linkages to specialty consultation and training for community providers and families to increase the organization and capacity to effectively service CYSHCN in their own communities. Communities have indicated that their capacity to partner with

OCCYSHN is, in some cases, challenged by the impact of Oregon's economic status as it is playing out in their community-based organizations.

The CaCoon (Care Coordination) Program, operating in all of Oregon's 36 counties with specially trained public health nurses, will experience a 10% reduction in funding to the local health departments. This may reduce the number of children seen within the communities by an equivalent 10%, or approximately 170 children.

The Family Support Program, which has provided limited funds ($275,500) to CYSHN and their families who reside in Oregon to purchase supplies, equipment, and other needed services not covered by health insurance or other sources, is not accepting new applications. Through changes to accommodate the state budget crisis, the funds available to support families was reduced by over half. The program is currently closed for re-evaluation and redesign to accommodate significantly reduced funding and need for administrative streamlining.

The Family Involvement Network (FIN) is a statewide network of CYSHN families who provide parent perspectives across OCCYSHN and CDRC activities, serve as team members on CCN teams. Family consultants in OCCYSHN train FIN parents on working with health professionals and on multi-disciplinary teams; arrange family input to OCCYSYN program and on CYSHN issues; partner with parent organization; and promote family centered-care. The FIN consultants have been reduced from 1.5 FTE to one half-time parent consultant. Support to the family liaisons that are community-based will be maintained into FY10.
//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.